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INTRODUCTION

This booklet is the Plan Document for the Broome County HMO Red Medical Plan and is also intended to operate as your Summary Plan Description. We invite you to carefully review these Plan provisions. This booklet explains the benefits available to you and your family through the Plan. This comprehensive Plan helps to provide financial security for you and your family when you are faced with large health care expenses. We hope this booklet will serve not only as a guide but also as evidence of our concern for the welfare of you and your family.

Covered Services under the Plan will be subject to any Coinsurance, Copayments, maximums and deductible amounts as applicable as shown in the Schedule of Benefits.

This booklet is not an employment contract or an offer to enter into an employment contract. Retirement does not in any manner confer upon a Covered Family Member any right to continued benefits under this Plan. This Plan is not subject to ERISA. For more information regarding your rights as a participant under this Plan, see the section entitled Statement of Rights.

It is our intention to continue the Plan indefinitely and to make contributions to the Plan. However, we reserve the right to amend the Plan at any time and will notify you within 60 days after the effective date of any Plan amendment that would reduce any benefit. We also reserve the right to terminate the Plan at any time provided that we have given you at least 60 days advance notice of our intention to do so. Should the Plan be terminated for any reason, the assets of the Plan, if any, will continue to be used to provide benefits for Covered Services received before the date of the termination, in the order received, until such time as the assets, if any, are exhausted.

If you have any questions relating to Eligibility, classification or coverage under the Plan, submit them to the Plan Administrator.

How the Plan Works: This Plan requires referrals or Prior Authorization from the PCP for additional services including the care of a specialist. The PCP may obtain a referral or Prior Authorization by calling the toll-free number on the back of the Covered Family Member's benefit identification card. When obtaining a referral or Prior Authorization for a hospital admission, surgery or other treatment that includes ancillary services such as anesthesia, radiology and pathology, the PCP is only required to Pre-Authorize the admission or the main procedure, not the ancillary services. The following services do not require a PCP referral:

- (1) Emergency services; however, the Covered Family Member must get a referral from their PCP for follow-up care.
- (2) Obstetric and gynecological services.
- (3) Routine eye exams.

The Claim Administrator will pay benefits directly to the Provider for Covered Services less any applicable Coinsurance, deductible, or Copayment. If you or your Covered Dependent seeks care or treatment from a provider who is not a member of the Preferred Provider Network or does not obtain a referral for additional services, medical expense benefits will be denied. If a non-participating provider must be utilized, the Covered Family Member or referring provider is responsible for notifying RMSCO Medical Management at least 10 days prior to the service. Otherwise, benefits will be denied.

Due to changes that may occur in the participation status of the Provider, it is the responsibility of the Employee to verify that the Provider is still a Participating member. A list of Preferred Providers is available from your Employer, or via the Internet at www.rmscoinc.com.

**BROOME COUNTY HEALTH PLAN
RMSCO RED HMO PLAN
SCHEDULE OF BENEFITS
EFFECTIVE JANUARY 1, 2007**

Applies to: Active Employees, Retirees, COBRA Beneficiaries, and their Dependents.
Claims must be filed no later than 180 days after the date the claim is incurred or as otherwise stated in the Summary Plan Description or the claim will be denied.

TYPE OF SERVICE	IN-NETWORK PLAN The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. Requires PCP and referral procedures to specialists and facilities.
Hospital (also see Mental Illness, Substance Abuse, and maternity care for inpatient benefits) <ul style="list-style-type: none"> • Inpatient Hospital ⁽¹⁾ • Outpatient Hospital <ul style="list-style-type: none"> -Emergency room for a medical Emergency (includes ER physician) -Outpatient surgical center ⁽¹⁾ -Clinic -Laboratory -Diagnostic x-rays and tests -Diagnostic machine studies and tests ⁽¹⁾ -Diagnostic procedures ⁽¹⁾ (colonoscopy, etc.) -Radiation/chemotherapy -Physical/occupational/speech/therapy ⁽¹⁾⁽²⁾ -Respiratory therapy -Cardiac rehabilitation -Dialysis or hemodialysis 	<p style="text-align: center;">Covered in full up to the semi-private room rate</p> <p style="text-align: center;">\$50 Copayment Waived if admitted</p> <p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">See surgery benefit</p> <p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">\$15 Copayment per visit</p> <p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">\$15 Copayment; need approval from RMSCO Medical Management after initial 12 visits</p> <p style="text-align: center;">\$15 Copayment</p>
Freestanding Surgical Facility ⁽¹⁾	\$15 Copayment
Urgent Care	
<ul style="list-style-type: none"> • In Urgent Care Facility • After hours in PCP's office 	<p style="text-align: center;">\$50 Copayment</p> <p style="text-align: center;">\$15 Copayment</p>
Ambulance ⁽¹⁾ (Air ambulance not covered)	Covered in full
Preadmission/Preoperative Testing	Covered in full

- (1) Pre-Certification or Prior Notice is required for all elective inpatient hospital admissions (excluding maternity admissions, which require Post-Certification if stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section); certain elective outpatient surgical procedures; transplant procedures; surgical procedures (except for office surgeries); advanced infertility treatment; hospice care; home health care; speech therapy; advanced imaging procedures such as MRIs and CAT scans; non-emergency ambulance services; outpatient mental illness services; and durable medical equipment, prosthetics, and orthotics exceeding \$500. If utilizing non-participating providers, the member or Provider is responsible for notifying RMSCO Medical Management at least 10 days prior to the service.
- (2) Benefits for physical, speech, and occupational therapies are combined and covered for up to a 2 month maximum per acute condition per calendar.

TYPE OF SERVICE	IN-NETWORK PLAN The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. Requires PCP and referral procedures to specialists and facilities.
Convalescent/Skilled Nursing Facility <ul style="list-style-type: none"> Inpatient ⁽¹⁾ (Limited to 45 days maximum per Calendar Year) 	Covered in full
Physical Rehabilitation Facility ⁽¹⁾ (Limited to 60 days maximum per occurrence)	Covered in full
Home Health Care ⁽¹⁾ (Unlimited visits) Includes aide visit or nurse/therapist shift service, home IV therapy and respiratory care	Covered in full
Hospice Care ⁽¹⁾ (Limited to 210 days per Lifetime) Includes up to five visits for bereavement counseling	Covered in full
Private Duty Nursing	Not covered
Mental Illness Services <ul style="list-style-type: none"> Inpatient ⁽¹⁾ (Hospital or Behavioral Health Care Facility) (Limited to 30 days maximum per Calendar Year) Inpatient Physician (Limited to 20 visits per Calendar Year) Outpatient ⁽¹⁾ (Hospital clinic, facility, office) (Limited to 20 visits maximum per Calendar Year) 	Covered in full \$45 Copayment of 50% (whichever is less) \$15 Copayment – 1 st visit \$25 Copayment – 2 nd – 5 th visit \$45 Copayment or 50% (lesser) – 6 th – 20 th visit
Substance Abuse Treatment <ul style="list-style-type: none"> Inpatient Rehabilitation Inpatient physician for rehabilitation Inpatient Detoxification ⁽¹⁾ (Hospital or Behavioral Health Care Facility) (Limited to a 7 days maximum per Calendar Year) Inpatient physician for detoxification Outpatient (Hospital clinic, facility, office) (60 visits maximum per Calendar Year max) 	Not covered Not covered Covered in full Not covered \$15 Copayment

(1) Pre-Certification or Prior Notice is required for all elective inpatient hospital admissions (excluding maternity admissions, which require Post-Certification if stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section); certain elective outpatient surgical procedures; transplant procedures; surgical procedures (except for office surgeries); advanced infertility treatment; hospice care; home health care; speech therapy; advanced imaging procedures such as MRIs and CAT scans; non-emergency ambulance services; outpatient mental illness services; and durable medical equipment, prosthetics, and orthotics exceeding \$500. If utilizing non-participating providers, the member or Provider is responsible for notifying RMSCO Medical Management at least 10 days prior to the service.

TYPE OF SERVICE	IN-NETWORK PLAN The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. Requires PCP and referral procedures to specialists and facilities.
Maternity Care – Mother <ul style="list-style-type: none"> • Inpatient Hospital ⁽¹⁾ • Birthing Center ⁽¹⁾ • Physician for prenatal care and delivery and postnatal care 	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">\$15 Copayment for initial visit, remainder covered in full</p>
Newborn Care (Prior to discharge) <ul style="list-style-type: none"> • Hospital ⁽¹⁾ • Physician • Newborn circumcision 	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p>
Physician (except for routine care and delivery, or treatment of Mental Illness or Substance Abuse) <ul style="list-style-type: none"> • Inpatient visit • PCP Office visits • Home visit • Consultation (Specialist) <ul style="list-style-type: none"> -Inpatient -Outpatient -Office • Surgery ⁽¹⁾ <ul style="list-style-type: none"> -Inpatient -Outpatient -Office -Assistant surgeon • Second medical or surgical opinion – voluntary 	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">\$15 Copayment</p>
Chiropractor	<p style="text-align: center;">\$15 Copayment per visit</p>
Podiatrist <ul style="list-style-type: none"> • Visit • Foot orthotics • Surgery ⁽¹⁾ 	<p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">Not covered</p> <p style="text-align: center;">See surgery benefit</p>

(1) Pre-Certification or Prior Notice is required for all elective inpatient hospital admissions (excluding maternity admissions, which require Post-Certification if stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section); certain elective outpatient surgical procedures; transplant procedures; surgical procedures (except for office surgeries); advanced infertility treatment; hospice care; home health care; speech therapy; advanced imaging procedures such as MRIs and CAT scans; non-emergency ambulance services; outpatient mental illness services; and durable medical equipment, prosthetics, and orthotics exceeding \$500. If utilizing non-participating providers, the member or Provider is responsible for notifying RMSCO Medical Management at least 10 days prior to the service.

TYPE OF SERVICE	IN-NETWORK PLAN The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. Requires PCP and referral procedures to specialists and facilities.
Preventative/Well Care <ul style="list-style-type: none"> • Routine GYN exam, including Pap smear (Two per Calendar Year) • Routine Pap smears (Two per Calendar Year) • Mammogram • Prostate cancer screenings • Routine colon cancer screening ⁽¹⁾ • Bone density testing • Well child care to age 19 (As recommended by physician; includes routine immunizations) • Routine adult physicals, includes associated labs and x-rays and appropriate routine immunizations (Limited to one per Calendar Year) • Routine eye exam (One every 24 months; does not include eyewear) • Routine hearing evaluations • Hearing aids 	<p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered under routine care</p> <p style="text-align: center;">Covered under routine care</p> <p style="text-align: center;">Covered under routine care</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">Routine hearing exams are covered when part of routine annual physical and do not carry a separate Copayment</p> <p style="text-align: center;">Not covered</p>
Outpatient Diagnostic Tests (Freestanding facility and home) <ul style="list-style-type: none"> • Laboratory • Diagnostic x-rays and tests • Diagnostic machine studies and tests ⁽¹⁾ • Diagnostic procedures ⁽¹⁾ (colonoscopy, etc.) 	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">See surgery benefit</p>
Outpatient Treatments (Freestanding facility and physician's office) <ul style="list-style-type: none"> • Chemotherapy • Radiation therapy 	<p style="text-align: center;">\$15 Copayment</p> <p style="text-align: center;">\$15 Copayment</p>

(1) Pre-Certification or Prior Notice is required for all elective inpatient hospital admissions (excluding maternity admissions, which require Post-Certification if stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section); certain elective outpatient surgical procedures; transplant procedures; surgical procedures (except for office surgeries); advanced infertility treatment; hospice care; home health care; speech therapy; advanced imaging procedures such as MRIs and CAT scans; non-emergency ambulance services; outpatient mental illness services; and durable medical equipment, prosthetics, and orthotics exceeding \$500. If utilizing non-participating providers, the member or Provider is responsible for notifying RMSCO Medical Management at least 10 days prior to the service.

TYPE OF SERVICE	IN-NETWORK PLAN The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. Requires PCP and referral procedures to specialists and facilities.
Durable Medical Equipment ⁽¹⁾	80%
External Prosthetics/Orthotics ⁽¹⁾	80%
Internal Prosthetics ⁽¹⁾	80%
Medical Supplies	80%
Diabetic Treatment <ul style="list-style-type: none"> • Education • Supplies and insulin • Diabetic equipment ⁽¹⁾ 	\$15 Copayment 20% Copayment or \$15, whichever is less 20% Copayment or \$15, whichever is less
Family Planning Services <ul style="list-style-type: none"> • Elective sterilization procedures ⁽¹⁾ • Elective abortions ⁽¹⁾ 	See surgery benefit See surgery benefit
Anesthesia (Inpatient, outpatient, and office)	Covered in full
Allergy Care <ul style="list-style-type: none"> • Treatment (injections), includes serum • Laboratory and scratch testing 	Covered in full \$15 Copayment
Outpatient Services & Therapy (Freestanding facility or physician's office) Physical/speech/occupational/therapies ⁽¹⁾⁽²⁾ Respiratory therapy Cardiac rehabilitation Dialysis or hemodialysis Infusion therapy	\$15 Copayment per visit \$15 Copayment \$15 Copayment; need approval from RMSCO Medical Management after initial 12 visits \$15 Copayment \$15 Copayment
Transplant Services ⁽¹⁾	Covered in full
Preventative Dental for Children up to age 19 Periodic exams, x-rays, cleanings, fluoride treatments and sealants – any dentist	\$15 Copayment
Student Away From Home Coverage	\$15 Copayment per visit (non-routine care) \$2,500 per Calendar Year maximum for treatment rendered by a non-participating physician or care not coordinated through the PCP. Services coordinated through the PCP will be paid at normal Plan benefits.

(1) Pre-Certification or Prior Notice is required for all elective inpatient hospital admissions (excluding maternity admissions, which require Post-Certification if stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section); certain elective outpatient surgical procedures; transplant procedures; surgical procedures (except for office surgeries); advanced infertility treatment; hospice care; home health care; speech therapy; advanced imaging procedures such as MRIs and CAT scans; non-emergency ambulance services; outpatient mental illness services; and durable medical equipment, prosthetics, and orthotics exceeding \$500. If utilizing non-participating providers, the member or Provider is responsible for notifying RMSCO Medical Management at least 10 days prior to the service.

(2) Benefits for physical, speech, and occupational therapies are combined and covered for up to a 2 month maximum per acute condition per calendar.

MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

Calendar Year Deductible	Not applicable
Out-of Pocket Maximum	Not applicable
Lifetime Maximum	None

PRESCRIPTION DRUG PLAN

Retail Up to a 30-day supply Includes contraceptives	<ul style="list-style-type: none"> • \$ 5 Copayment – Generic Drug • \$20 Copayment – Preferred Brand Name Drug • \$40 Copayment – Non-Preferred Brand Name Drug
Mail Order Maintenance Drugs Up to a 90-day supply	<ul style="list-style-type: none"> • \$10 Copayment – Generic Drug • \$40 Copayment – Preferred Brand Name Drug • \$80 Copayment – Non-Preferred Brand Name Drug

SELECTED SURGICAL AND IMAGING PROCEDURES

The following Surgical and Imaging Procedures require Pre-Certification

- Diagnostic Laparoscopy;
- Lumbar Laminectomy (Discectomy);
- Hysterectomy;
- Septoplasty;
- Sinus Surgery;
- Spinal Fusion;
- Cataract Surgery;
- Hammer Toe Surgery;
- Hemorrhoidectomy;
- Shoulder Arthroscopy;
- Gastric Bypass Surgery/Gastroplasty;
- Blepharoplasty;
- Breast Implantation;
- Breast Reduction;
- Cochlear Implant;
- Oral Surgery/Orthognathic Surgery;
- Rhinoplasty;
- MRI/MRA, CAT, PET Scans; and
- Nuclear Cardiology

Note: Services must be Medically Necessary treatment of Sickness or Injury, unless as otherwise stated above. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary. This Schedule of Benefits is intended to be a general summary only. Some limitations, conditions, or exclusions may apply. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail.

DEFINITIONS OF SOME TERMS USED IN THIS BOOKLET

The terms defined in this section have been capitalized throughout this document.

Active Service means that you are performing all the regular duties of your employment with us either at one of our business establishments or at some location to which we require you to travel. You will be considered in Active Service on a day that is not one of our scheduled workdays only if you were performing the regular duties of your employment on the preceding scheduled workday. The term Active Service includes periods during which an Employee is absent from work due to a medically related reason and any scheduled or approved day off.

Adoption Date means the January 1, 2007 restated effective date.

Adverse Benefit Determination or Adverse Determination means any whole or partial denial of benefits, reduction of benefits, termination of benefits, or failure to provide or make benefit payment under the Plan. An Adverse Benefit Determination includes, but is not limited to, amounts applied to the deductible, a Copayment, or a Coinsurance percentage payable by a Covered Family Member, or an amount applied as a penalty when Plan procedures are not followed. Adverse Determination also applies to a Covered Family Member's eligibility, the application of Prior Authorization or referrals, the determination of an Experimental or Investigational treatment, and the determination of Medical Necessity.

Allowable Expense means a health care service or expense, including deductibles, Coinsurance or Copayments that is covered in full or in part under this Plan or any Other Plan(s) covering the Family Member.

Authorized Representative means any individual designated by the Covered Family Member to assist or act on behalf of the Covered Family Member with respect to a Pre-Service Claim, a Post-Service Claim, a Concurrent Claim, or an Urgent Care Claim. A Provider with knowledge of the Covered Family Member's medical condition is an Authorized Representative. An Authorized Representative may request and receive any documentation that the Plan used to make a determination, including medical records.

Behavioral Health Care Facility means a facility that specializes in the treatment of Substance Abuse or Mental Illness which is certified in accordance with the applicable laws of the appropriate legally authorized agency, which is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), Medicare, or by the state in which it operates. For Covered Family Members who are entitled to Medicare, a Behavioral Health Care Facility must be a provider of services under Medicare.

Benefit Determination or Determination of Benefits means the calculation made by the Claim Administrator of any amount payable by the Plan. The Determination of Benefits payable will be made whenever proof of claim is submitted.

Brand Name Drug means a drug that is protected by the trademark registration of the pharmaceutical company that produces it.

Business Associate means a person or organization, other than one which is a member of the Covered Entity's workforce, that has a direct contractual relationship with the Covered Entity and which receives, uses, discloses, or maintains Protected Health Information for the Covered Entity.

Calendar Year means the twelve month period beginning at 12:01 A.M. Eastern Time on January 1st and ending at 12:00 Midnight Eastern Time on December 31st. However, if you were not Covered under this Plan for this entire period, Calendar Year means the period from your Participation Effective Date until 12:00 Midnight Eastern Time on December 31st.

Change in Status means any one of the following changes in circumstances:

- (1) Your marriage, divorce, legal separation or annulment.
- (2) Death of your spouse or other dependent.
- (3) A change in the number of your qualifying dependents or their eligibility, including:
 - (A) Birth of your child.
 - (B) Adoption or placement for adoption of a child with you.
 - (C) Your child satisfies, or ceases to satisfy the eligibility requirements.
- (4) You or your Dependent have a change in employment status that causes a gain or loss of coverage under this Plan or another employer plan providing the same benefits, including:
 - (A) Commencement or termination of employment, including a strike or lockout
 - (B) Commencement or return from an unpaid leave of absence.
 - (C) An eligibility status change for the Plan.
- (5) A change in residence that affects eligibility for coverage. (Applies to Retirees only.)

Note: No changes will be permitted unless the requested change satisfies the consistency rule as required by the IRS. This means that any requested election change must be on account of and correspond with the Change in Status that has occurred.

Child means your unmarried, biological Child, stepchild, or legally adopted Child, a Child for whom you are the legal guardian, or a child whose legal custody is transferred to the Employee or the Employee's spouse pursuant to a court order or decree. The child must be under age 19 or meet the definition of a Dependent Student.

The Child must rely on you for at least 51% of his or her support. This requirement may be waived if you are not required to provide this support. A legally adopted Child must have been placed for adoption (whether or not the adoption is final) before the Child's 18th birthday in order to be Eligible under this Plan. Child also means any other individual for whom you are obligated to provide coverage under the terms of any Qualified Medical Child Support Order.

Coverage for any Child who is mentally or physically handicapped, mentally ill, or developmentally disabled, and incapable of self-sustaining employment can be continued after they reach age 19 (or age 25 if a Dependent Student) if their disability began prior to age 19 (or 25 if a Dependent Student). The disabled Child must be dependent on you for financial support, as defined by the Internal Revenue Code and the Covered Employee must declare the Child as an income tax deduction. The Employee must provide proof that the Child is incapable of self-sustaining employment within 31 days of the Child's 19th (or 25th if a Dependent Student) birthday. The disabled Child must meet the above support requirements and submit proof of disability to the Claim Administrator upon request.

A newly hired Employee may also add a disabled child as a Dependent under the Plan provided the Child is incapable of earning his own living and the disability began prior to age 19 (or age 23 if a Dependent Student). The disabled Child must have been continually dependent upon you prior to and beyond age 19 and must remain dependent upon you for financial support, as defined by the Internal Revenue Code and the Covered Employee must declare the Child as an income tax

deduction. The Child must have been continuously covered under another health plan from the time they were deemed disabled until the date of enrollment in this Plan. If the Child's coverage lapsed at any time prior to enrollment in this Plan, the rules regarding creditable coverage as defined by HIPAA will apply.

The Plan requires documentation proving financial dependency, including tax records and proof of continuous coverage under any previous plan(s). The Plan also requires subsequent proof of medical disability and financial dependency once each year. The Plan reserves the right to have such Child examined by a physician of the Plan's choice, at the Plan's expense, to determine such incapacity.

Claim Administrator means RMSCO, Inc.

Claim Determination Period means Plan benefits will be determined on a Calendar Year basis.

COBRA Beneficiary means a Covered Family Member who is entitled to and elects to continue health coverage under this Plan in accordance with Section 4980B of the Code. The term will also include a Child who is born or placed for adoption, and any other Eligible Dependent acquired while the Employee is a COBRA Beneficiary.

Code means the Internal Revenue Code of 1986, as presently enacted and as it may be amended from time to time, together with its related rules and regulations. References to any Section of the Code shall include any successor provision.

Coinsurance means the percentage of an Allowable Expense shared by the Covered Family Member and the Plan that must be paid to the Provider.

Coinsurance Maximum or **Out-of-Pocket Maximum** means the total amount of Coinsurance that a Covered Family Member must pay in a Calendar Year as indicated on the Schedule of Benefits.

Concurrent Claim means a request for benefits arising out of a termination of benefits, request for extension of care or reduction of previously granted benefits being provided over a period of time, or a request to extend a course of treatment.

Convalescent/Skilled Nursing Facility means only an institution (or a distinct part thereof) that meets all the following requirements:

- (1) It meets any licensing or certification standards, and
- (2) It provides inpatient skilled nursing and physical restoration services for patients convalescing from an Injury or Sickness, and
- (3) It is under the full-time supervision of a physician or registered professional nurse who is regularly on the premises at least 40 hours per week, and
- (4) It provides skilled nursing services on a 24-hour basis under the direction of a full-time registered professional nurse, with licensed nursing personnel on duty at all times, and
- (5) It maintains a complete medical record on each patient, and
- (6) It has a utilization review plan in effect for all of its patients, and
- (7) It must have a written agreement or arrangement with a physician to provide Emergency care, and

- (8) If not an integral part of a Hospital, it must have a written agreement with one or more Hospitals to provide for the transfer of patients and medical information between the Hospital and the Convalescent/Skilled Nursing Facility, and
- (9) With respect to Covered Family Members who are entitled to Medicare, it is an approved provider of services under Medicare, and
- (10) It is accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO).

The term Convalescent/Skilled Nursing Facility will not include any institution which is, other than incidentally, a place for the aged, the blind, the deaf, the mentally ill or handicapped, a place for rest, Custodial Care or educational care, drug addicts or alcoholics.

Copayment or **Copay** means a fixed dollar amount paid to a Provider by a Covered Family Member.

Covered means that a Family Member who is Eligible to participate in the Plan has made written election to do so, and the Plan Administrator has approved participation.

Covered Entity means a health plan, a health care clearinghouse, or a Provider who transmits health information in an electronic form in connection with a Standard Transaction.

Covered Services means those services for which the Plan will make payment. A Covered Service may include routine or Medically Necessary health care for which a diagnosis is identified in the International Classification of Diseases, 9th edition (ICD-9). Covered Services should be identified in the Current Procedural Terminology (CPT) developed by the American Medical Association, by the Common Procedure Coding System (HCPCS) developed by the Health Care Financing Administration, the Hospital Revenue Code applications, or the Current Dental Terminology (CDT) developed by the American Dental Association.

Custodial Care means any service or supply, including room and board, which:

- (1) Is furnished mainly to help a person in the activities of daily living, and
- (2) Can be furnished by someone with no professional health care training or skills.

Room and board and skilled nursing services, when provided to a Covered Family Member in a Hospital or other institution, shall not be Custodial Care when such services must be combined with other Medically Necessary services and supplies to establish a program of medical treatment which can reasonably be expected to contribute substantially to the improvement of the Covered Family Member's medical condition. Such improvement shall include the restoration of normal or near normal function and/or the general betterment of the Covered Family Member.

Dependent means your Child or legal spouse as defined in the State's Defense of Marriage Act from whom you are not legally separated or legally divorced or a legal spouse of an Employee whose marriage has not been legally annulled. A common law spouse, civil union partner, same-sex spouse, or domestic partner is not recognized as your legal spouse under the Plan, even if it is recognized in the State or municipality of residence.

Dependent Student means an unmarried, Eligible Child who is age 19 or older, but who has not yet reached their 25th birthday. The Child must be registered as a full-time student and in full-time attendance at a school accredited by the Education Department of the state in which it operates. A full-time student is a student that is enrolled for at least 12 credit hours per semester. Attendance may include online college courses. A Dependent Student will be Covered during a period of vacation, break time, or temporary disability provided he has expressed an intent, through pre-registration, to attend during the next subsequent school period.

If a Dependent later enrolls as a full-time student at an accredited school, and they continue to meet the definition of a Dependent Student, the Employee must complete a Change Form and a Full-Time Student Verification form and submit them to the Plan Administrator within 30 days of the Child returning to school in order for the Child to be reinstated to coverage, provided the Employee has already enrolled for family coverage and it is in effect. Coverage will begin on the Child's date of registration. If the Employee does not submit the forms listed above, the Child must wait until the next Open Enrollment Period to enroll in the Plan.

Any unmarried Dependent between the ages of 19 and 25 who previously was not eligible for benefits or had benefits ended and returns to a full-time student status may be reinstated to family coverage. Such reinstatement will be effective on the date that the student commenced full-time attendance at an accredited school. The Employee must complete a Change Form and a Full-Time Student Verification form and submit them to the Plan Administrator within 30 days of the Child returning to school in order for the Child to be reinstated to coverage,

Durable Medical Equipment means medical equipment that satisfies all the following requirements:

- (1) It is generally not useful in the absence of an Injury or a Sickness, and
- (2) It is appropriate for use in the home, and
- (3) It can withstand repeated use, and
- (4) It is Medically Necessary, and
- (5) It is not useful or convenient to other household members, and
- (6) It is not a convenience item or an aid to daily living.

Eligible means that an individual has met the definition of Family Member and the eligibility requirements of this Plan.

Emergency means a sudden onset of symptoms that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably determine that the absence of immediate medical attention would result in serious physical impairment or death. It also means a situation in which a Covered Family Member appears to have a mental or emotional disorder for which immediate observation, care and treatment is necessary to avoid serious harm to the Covered Family Member or others. Emergency treatment must be rendered within 72 hours of an Injury or within 12 hours of onset of a sudden and serious illness.

Employee means an individual whose income is reported for tax purposes using a W-2 form.

Employer or **Company** means Broome County and any affiliate companies and subsidiaries that adopt this Plan.

Experimental or **Investigative** means services, supplies, care and treatment that do not constitute accepted medical practice. When determining whether or not a procedure is Experimental or

Investigative, the Plan will take into consideration appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. It will be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan will be guided by the following principles:

- (1) The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, except where the laws of the state mandate coverage for any drug not approved by the FDA but recognized as appropriate treatment for a particular type of cancer by an established reference such as the AMA Drug Evaluations, or
- (2) The drug, device, medical treatment or procedure, or the patient informed consent document was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval, or
- (3) Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, or
- (4) Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy compared with a standard means of treatment or diagnosis.

Family Member means an Employee, Surviving Spouse, Dependent, or a COBRA Beneficiary.

Freestanding Surgical Facility means an institution primarily performing outpatient surgery that meets all the following requirements:

- (1) It has a medical staff of physicians, nurses and licensed anesthesiologists, and
- (2) It maintains at least two operating rooms and one recovery room, and
- (3) It maintains diagnostic laboratory and x-ray facilities, and
- (4) It has equipment for Emergency care, and
- (5) It has a blood supply, and
- (6) It maintains medical records, and
- (7) It has agreements with Hospitals for immediate acceptance of patients who need Hospital confinement on an inpatient basis, and
- (8) It is licensed in accordance with the laws of the appropriate legally authorized agency, and
- (9) It is a provider of services under Medicare with respect to Covered Family Members who are entitled to Medicare, and
- (10) It is accredited by the Accreditation Association for Ambulatory Care (AAAC), or the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

Generic Drug means the chemical name for a drug. By law, a Generic Drug must meet the same standard for safety, surety, strength and effectiveness as a Brand Name Drug.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency means a hospital, agency or organization that meets all the following requirements:

- (1) It primarily provides skilled nursing services or other therapeutic services and is duly licensed by the appropriate licensing authority, and
- (2) It has policies established by a professional group associated with the agency or organization consisting of at least one physician and at least one registered professional nurse to govern the services provided (it must provide for full-time supervision of such services by a physician or by a registered professional nurse), and
- (3) It maintains a complete medical record on each patient, and
- (4) It has a full-time administrator, and
- (5) It is a provider of services under Medicare with respect to Covered Family Members who are entitled to Medicare, and
- (6) It does not primarily provide Custodial Care, care and treatment of the mentally ill, or care of drug addicts, alcoholics, and the handicapped.

Hospice Care Agency means a hospital, agency or organization that meets all the following requirements:

- (1) It has hospice care available 24-hours-a-day, and
- (2) It meets any licensing or certification standards of the jurisdiction where it is located, and
- (3) It provides skilled nursing services, medical social services, psychological and dietary counseling, and bereavement counseling for the immediate family, and
- (4) It provides or arranges for other services including; (a) services of a physician, (b) physical or occupational therapy, (c) part-time Home Health Aide services which mainly consist of caring for terminally ill individuals, and (d) inpatient care in a facility when needed for pain control, and
- (5) It has personnel including at least one physician, one registered professional nurse, one licensed or certified social worker and one pastoral or other counselor, and
- (6) It establishes policies governing the provision of hospice care, and
- (7) It assesses the patient's medical and social needs, and
- (8) It develops a hospice care program to meet those needs, and
- (9) It provides ongoing quality assurance programs including reviews by physicians, other than those who own or direct the agency, and
- (10) It permits all area medical personnel to utilize its services for their patients, and
- (11) It keeps a medical record on each patient, and
- (12) It uses volunteers trained to provide services for non-medical needs, and
- (13) It has a full-time administrator, and
- (14) It is a provider of services under Medicare with respect to Covered Family Members who are entitled to Medicare.

Hospice Facility means a facility which mainly provides hospice care and provides nursing services 24 hours a day under the direction of a Registered Nurse (RN) and meets any licensing or certification standards set forth by the jurisdiction in which it operates. It must employ a full time administrator, physician or RN and maintain complete medical records on each patient.

Hospital means a licensed institution that meets all the following requirements:

- (1) It primarily provides, for compensation from its patients and on an inpatient basis, all facilities necessary for medical and surgical treatments, and care of injured and sick persons by or under the supervision of a staff of physicians, and
- (2) It continuously provides 24-hour-a-day nursing service by registered professional nurses, and
- (3) It is not a primary place for rest, a place for the aged, or a nursing home, and
- (4) It is not primarily a place providing convalescent/skilled nursing care, rehabilitation care, Custodial Care, hospice care, treatment of Mental Illness or Substance Abuse, a health resort or spa, a sanitarium, an infirmary at any school, college or camp, and
- (5) For Covered Family Members who are entitled to Medicare it means a facility that is a provider of services under Medicare, and
- (6) It is accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

Additionally, the following institution will qualify under this definition:

- (7) A licensed birthing center that:
 - (A) Provides care and treatment for Covered Family Members during uncomplicated pregnancy, routine full-term delivery, and immediate postpartum care, and
 - (B) Provides full-time skilled nursing services, and
 - (C) Is staffed and equipped to give Emergency care, and
 - (D) Has a written arrangement with a local Hospital for Emergency care, and
 - (E) Is a provider of services under Medicare with respect to Covered Family Members who are entitled to Medicare, and
 - (F) Is approved for its stated purpose by the Accreditation Association for Ambulatory Care.

Injury means an accidental loss, unforeseen impairment, or physical harm inflicted on the body by unexpected, external means.

Lifetime means a period of time for which benefit maximums and limitations apply while a Family Member is Covered under this Plan. Only one Lifetime benefit will apply to an Employee who remains Covered under the Plan, whether or not the Employee retires from Active Service.

Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended from time to time.

Medical Services Team means an organization engaged by the Plan Administrator and/or the Claim Administrator for the purposes of providing utilization review and medical case management services for the Plan. In addition, the Medical Services Team will provide services as may be determined by the Plan Administrator or Claim Administrator.

Medically Necessary or **Medical Necessity** means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (1) In accordance with generally accepted standards of medical practice;
- (2) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- (3) Not primarily for the convenience of the patient, physician, or other health care provider, and
- (4) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community when available, Physician Specialty Society recommendations, the views of prudent physicians practicing in relevant-clinical areas, and any other clinically relevant factors.

Medicare means the program of medical care benefits for the aged and persons with disabilities provided under Title XVIII of the Social Security Act of 1965, as amended from time to time.

Mental Illness means a mental or an emotional disorder as defined and classified by appropriate ICD-9 coding, regardless of cause, which is characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominating feature.

Non-Emergency means the onset of symptoms that do not require Emergency care. The determination of what is considered a non-Emergency will be made by the Claim Administrator or Plan Administrator in their sole discretion.

Non-Occupational Disease means a Sickness which does not arise out of or in the course of any employment for compensation, profit, intent of profit, or self-employment, nor, in any way, results from a condition that does. However, if proof is furnished to the Claim Administrator that an individual covered under a workers' compensation law (or other law of similar purpose) is not covered for a particular disease under such law, that disease shall be considered "non-occupational" regardless of its cause.

Non-Occupational Injury means an accidental bodily Injury that does not arise out of or in the course of any employment for compensation, profit, intent of profit, or self-employment.

Open Enrollment Period means the time period before the end of each Calendar Year during which Eligible Employees and/or their Dependent(s) may enroll in or change their election in the Plan. The effective date of coverage will be the January 1st that immediately follows the Open Enrollment Period.

Other Plan means arrangements of group insurance or group subscriber contracts (other than this Plan) through HMOs, Medicare or other government benefits, portions of group long-term care contracts, i.e. skilled nursing care, and other prepayment, group practice, and individual practice plans. Group-type contracts, through membership in a particular organization or group, which are not available to the general public, group hospital indemnity benefits in excess of \$200 per day, and

group or individual automobile “no-fault”, traditional “fault”, or tort type policies are also considered other plans. All provide medical, dental, or optical benefits or services on an insured or an uninsured basis.

Other plan does not include individual or family insurance policies, subscriber contracts, group or group-type hospital indemnity benefits of \$200 per day or less, a state Medicaid plan or CHAMPUS/TRICARE. Also, school accident-type coverage, which cover students of elementary and secondary schools or colleges for accidents on either a 24-hour around-the-clock, or a to-and-from-school basis are not included.

Participation Effective Date means the earliest date on which coverage is first afforded to a Covered Family Member under this Plan.

Plan means the Broome County HMO Red Medical Plan adopted and maintained pursuant to this document which sets forth the rights and obligations of the persons entitled to benefits under the Plan and the procedures by which Plan fiduciaries may be identified.

Plan Administrator means the person(s) appointed Plan Administrator pursuant to the procedures in the section entitled “Responsibilities of the Plan Administrator”.

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

Post-Service Claim is a request for benefits made after the medical care or treatment has been provided to a Covered Family Member.

Pre-Authorize or **Prior Authorization** means the process used when a claim for medical care requires the referral described in the section entitled “Utilization Management and Medical Review” including a request for an extension of care or concurrent care.

Pre-Certification, Pre-Certify, or Post-Certification means the process used when a claim for medical care requires the certification described in the section entitled “Utilization Management and Medical Review” including a request for an extension of care or concurrent care.

Preferred Provider means a Health Care Provider who is a member of the Preferred Provider Network.

Preferred Provider Network means an organization of Health Care Providers who have entered into an agreement to provide Covered Services at a predetermined rate.

Preferred Provider Reimbursement Schedule means the schedule of Allowable Expenses payable for any Covered Services by an in-network Provider.

Pre-Service Claim means a request by a Covered Family Member for a benefit described in the section entitled “Utilization Management and Medical Review”. A Covered Family Member must contact the Claim Administrator prior to receiving the medical service or treatment. A Pre-Service Claim includes a claim that requires Pre-Certification, Prior Authorization, a claim for which a Covered Family Member must obtain a referral, and benefits that include a penalty for failure to obtain Prior Authorization, a referral or Pre-Certification.

Primary Care Physician (PCP) means a Preferred Provider who has an agreement with RMSCO to provide covered primary health care services to Covered Family Members. Each Covered Family Member must choose a PCP who is a Preferred Provider.

Prior Plan means the plan that was in effect directly prior to this Plan.

Privacy Officer means the person(s) designated by the Employer who is responsible for development, implementation, and compliance with the privacy policies and procedures as required by HIPAA.

Protected Health Information (PHI) means any information that relates to any Sickness or Injury that is created, transmitted or maintained either orally, electronically, or on paper that identifies or could be used to identify a Covered Family Member.

Provider or Health Care Provider means an individual who is operating within the scope of his license to provide Medically Necessary Covered Services. A physician operating within the scope of his license and who is licensed to prescribe medications, administer drugs, perform surgery or to provide Medically Necessary Covered Services is a Health Care Provider.

Provider will also include services of a certified nurse practitioner when services are performed directly under the supervision of a physician, and skilled nursing services rendered by a registered professional nurse or by a licensed practical nurse under the direction of a registered professional nurse. Provider will also include a certified nurse midwife for any Covered Service that is within the lawful scope of their practice regardless of their employment status by a physician. A certified nurse midwife need not act pursuant to a physician's orders. Provider will also include a licensed dentist, or a licensed practitioner who is practicing within the scope of his license and whose license is favorably accepted by the State or other jurisdiction in which the Covered Services are provided. The term Provider will also include a physician's assistant, podiatrist, osteopath, optometrist, psychiatrist, psychologist, chiropractor, speech therapist, occupational therapist, diabetic counselor, or licensed physical therapist acting within the scope of his license or certificate who is performing services that are covered by this Plan. When used in the treatment of Mental Illness, this term will also include a certified and registered social worker with at least six years of post-degree experience who has been qualified by the state in which they practice.

Qualified Medical Child Support Order (QMCSO) means any judgment, decree, or order (including approval of a property settlement agreement) issued by either a court of competent jurisdiction or through an administrative ruling that has the force and effect of state law. To be qualified, a QMCSO must satisfy the requirements of the law.

Reasonable and Customary means the smaller of:

- (1) The charge usually made for the service by the Provider who furnishes it, or
- (2) The prevailing charge made for the service, in the same geographic area, by Providers of similar professional standing, as determined by the Plan.

If the usual and prevailing charge for a service or supply cannot be easily determined because of the unusual nature of the service or supply, the Claim Administrator will determine to what extent the charge is a Reasonable and Customary charge, taking into account:

- (1) The nature and severity of the condition, and
- (2) The complexity involved, and

- (3) The degree of professional skill required, and
- (4) Any unusual circumstances which require additional time, skills or experience.

Reconstructive Surgery means surgery required because of trauma, infection or disease and a congenital disease or anomaly of a Covered Child which results in a functional defect. If a Covered Family Member requires Reconstructive Surgery to a breast following a covered mastectomy procedure, the term Reconstructive Surgery will also include surgery to the opposing breast to produce a symmetrical appearance.

Rehabilitation Facility means a facility that it is not already part of an acute care Hospital that mainly provides therapeutic and restorative services. It must be accredited for its stated purpose by either the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation for Rehabilitation Facilities (CARF). For Covered Family Members who are entitled to Medicare it means a facility that is a provider of services under Medicare for any Covered Family Member who is entitled to Medicare.

Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Residential Treatment Facility means a facility which specializes in the treatment of a particular Sickness or Injury, which is certified in accordance with the applicable laws of the appropriate legally authorized agency, and which is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), or the Commission on Accreditation for Rehabilitation Facilities, or by the state in which it operates. For Covered Family Members who are entitled to Medicare, a Residential Treatment Facility must be a provider of services under Medicare.

Retiree means any former Broome County Employee, Broome County Library Employee, Broome Community College Employee or elected Broome County official that has ten years of full-time equivalent employment or service in an office with the county, who is not entitled to health benefits pursuant to a collective bargaining agreement and who is receiving a benefit from the New York State Employees Retirement System or in the case of a former Broome Community College Employee, eligibility is pursuant to collective bargaining agreements and/or administrative rules.

Sickness means an unhealthy condition of the body, a disease, a mental or physical disorder, or pregnancy. The term Sickness means all such Sicknesses due to the same or related causes, including all complications or recurrences. The term Sickness does not mean an Injury. Sickness will include voluntary sterilization of both males and females, but not the reversal of a voluntary sterilization. Sickness will include elective abortions.

Special Enrollment Period means a 30-day period, as mandated under the terms of the Health Insurance Portability and Accountability Act of 1996, during which an Employee and/or his Eligible Dependent(s) may late enroll under this Plan if:

- (1) Such individual had previously declined coverage under this Plan, was covered under another health plan, and involuntarily lost such other coverage, or
- (2) The Employee acquires a new Dependent due to marriage, birth, adoption, or placement for adoption.

Standard Transaction means a transmission of information in a predetermined format between two or more parties to carry out financial or administrative activities related to the use and disclosure of Protected Health Information as required by the HIPAA Privacy Regulation.

Substance Abuse means the chronic abuse of alcohol or other drugs as defined and classified by the appropriate ICD-9 coding characterized by impaired functioning, debilitating physical condition, the inability to keep from or reduce consumption of the substance, or the daily use of the substance in order to function. The term Substance Abuse includes addiction to alcohol or other drugs, but not caffeine, tobacco, or food.

Surviving Spouse means the widow or widower of a deceased retired Employee.

Total Disability means that a Covered Family Member is prevented because of Injury or Sickness from engaging in any occupation on a total and continuous basis and is performing no work of any kind for compensation, profit, intent of profit, or self-employment. If a Dependent, the term means that he is prevented because of Injury or Sickness from engaging in substantially all of the normal activities of a person of like age and sex in good health. Additionally, if normally employed, the Dependent is not performing work for wage, profit, intent of profit, or self-employment, or engaging in any occupation on a total and continuous basis.

Treatment, Payment, or Health Care Operations means the medical, financial, or administrative activities required before the Plan can determine benefits including, but not limited to, the application of Standard Transactions, receipt of health care claims, health care payments, enrollment and disenrollment in the Plan, referral certification and authorization, and coordination or management of health care or related services by a Provider.

Urgent Care or Urgent Care Claim is a request for medical care or treatment that, if treated as non-Urgent Care could seriously jeopardize the Covered Family Member's life, health, or ability to regain maximum function. An Urgent Care Claim includes a request for medical care or treatment that would avoid subjecting the Covered Family Member to severe pain that cannot be adequately managed without the requested care or treatment.

The Plan will treat any claim as an Urgent Care Claim if a physician with knowledge of the Covered Family Member's medical condition determines that the claim involves Urgent Care.

An individual acting on behalf of the Plan may determine a claim to be an Urgent Care Claim by applying the judgment of a prudent layperson, possessing an average knowledge of health and medicine.

Urgent Care Facility means a medical facility that is open on an extended basis, is staffed by physicians to treat medical conditions not requiring inpatient or outpatient Hospital care, and which is not a physician's office.

Waiting Period means the initial number of consecutive days of employment of the employee by the Employer during which an Employee must be in continuous Active Service and full-time or half-time employment in an eligible class of employment prior to becoming Eligible to receive benefits under this Plan.

ELIGIBILITY AND PARTICIPATION

This section explains the eligibility requirements and when coverage under the Plan begins and ends. Employees may enroll for individual coverage as an Employee or for family coverage for their Dependents. Coverage will only begin if an Employee enrolls for this Plan's benefits. An Employee may not also be Eligible for coverage under this Plan as a Dependent of another Employee.

WHEN COVERAGE BEGINS

(Active Employees)

Employee Eligibility: All full-time Employees in Active Service who work 37.5 or 40 hours a week are Eligible to enroll for coverage under the Plan. All half-time Employees in Active Service who work 18.75 or 20 hours a week are Eligible to enroll for coverage under the Plan. Coverage (individual or family) for Plan benefits begins on the Participation Effective Date if:

- (1) The Employee completes an enrollment form requesting coverage within 30 days of the Employee's Participation Effective Date, and
- (2) The Employee authorizes a payroll deduction for the cost of the coverage requested by submitting a signed enrollment form.

If the above items are not completed prior to the expiration of the Waiting Period (or if there is no Waiting Period that applies to the Employee, then within 30 days from the Employee's first date of employment), then the Employee's enrollment will not be permitted until the next Open Enrollment Period, or if they qualify, pursuant to a special enrollment event.

Participation Effective Date: The Participation Effective Date is the earliest of the following:

- (1) When a new Employee begins Active Service, the Participation Effective Date is the date of hire provided that the Employee is working in Active Service on that date.
- (2) When a new Employee is not in Active Service on the Participation Effective Date, the Participation Effective Date is the date the Employee returns to Active Service.
- (3) Employees in Active Service who were Covered under the Prior Plan, the Participation Effective Date is the Adoption Date of this Plan.
- (4) Employees in Active Service who enroll for individual or family coverage during an Open Enrollment Period, the Participation Effective Date is the January 1st that immediately follows the Open Enrollment Period. The Employee must complete an enrollment form and payroll authorization form before the end of the Open Enrollment Period.
- (5) Employees in Active Service who enroll for individual or family coverage during a Special Enrollment Period, the Participation Effective Date is the date the Employee or their Dependent qualifies for the Special Enrollment Period. The Employee must complete an enrollment form and payroll authorization form within 30 days of the qualifying date.

Cost: The Employer and Covered Employees share the cost of this Plan's benefits. All Covered Employees contribute to the Plan in order to participate. Employees must authorize a payroll deduction for the cost of their coverage (individual or family). Contributions will be determined annually and may increase or decrease. Contributions will be based on claims the Plan experiences or other factors that the Plan Administrator deems relevant. Covered Family Members

are also responsible for any out-of-pocket expenses described in the Schedule of Benefits and services or supplies not covered under the Plan.

During any time period that the cost of this coverage shall be an eligible premium expense under any plan of benefits sponsored by your Employer under Section 125 of the Internal Revenue Code, you may be required to pay the cost of this coverage on a pre-tax basis.

Dependent Eligibility: All Eligible Dependents become Covered on the Employee's Participation Effective Date, provided that the Employee enrolls for family coverage. Dependents include the legal spouse of an Employee and the Child of an Employee. A Covered Child who becomes Totally Disabled will remain Covered during the time the Child is incapable of self-sustaining employment if the Employee submits proof of disability within 31 days of the date coverage would otherwise end.

Adding Coverage During an Open Enrollment Period: An Eligible Employee who waives coverage under this Plan may enroll during an annual Open Enrollment Period. The Employee must complete an enrollment form and authorize a payroll deduction for the cost of any individual or family coverage requested before the end of the Open Enrollment Period. The effective date of coverage elected during an Open Enrollment Period is the January 1st that immediately follows the Open Enrollment Period.

Adding Coverage During a Special Enrollment Period: An Eligible Employee may enroll for individual or family coverage during a Special Enrollment Period. The Employee must complete an enrollment form and authorize a payroll deduction for the cost of any individual or family coverage requested within 30 days of the event that qualifies the Employee for the Special Enrollment Period. The effective date of coverage will be the date the Employee acquires a new Dependent or the date the Employee or Dependent involuntarily lost coverage under another health plan if the enrollment forms are completed within 30 days of the qualifying date.

Mid-Year Election Changes: Under limited circumstances, you may modify or revoke your election at a time other than Open Enrollment if:

- (1) You have a Change in Status. The Change in Status must be consistent with a mid-year election change allowed under the Employer's Premium Conversion Plan or as defined by this Plan. Employees who are not participants in the Employer's Premium Conversion Plan can revoke coverage under this Plan at any time by discontinuing payment of premiums; however, they will not be able re-enroll for coverage except during an Open Enrollment Period or if they qualify for a Special Enrollment Period.
- (2) You qualify for a Special Enrollment Period.

Any modification or revocation and new election must be made within 30 days of the qualifying event causing a Change in Status or within 30 days of the qualifying event if you are eligible for a Special Enrollment Period. If no modification or new election is made during this 30-day period, you may not make a new election or modification until the next Open Enrollment Period.

This provision only applies to Employees who contribute to the Plan in order to participate.

WHEN COVERAGE ENDS (Active Employees)

Employee Coverage Ends: Employee coverage terminates on the earliest of the following:

- (1) The date the Plan is discontinued, or
- (2) The date the Employee no longer satisfies the eligibility requirements, or
- (3) The last day of the period for which you make any required contribution, or
- (4) The day on which the Covered Employee's Active Service with the Company terminates, or
- (5) The date of the Employee's death.

Dependent Coverage Ends: Dependent coverage will terminate on the earlier of:

- (1) The date the Plan is discontinued, or
- (2) The date the Employee's eligibility or coverage under the Plan terminates, or
- (3) The date the Dependent no longer qualifies as a Dependent, or
- (4) The date the Dependent becomes a Covered Employee under the Plan (except a Dependent Student hired temporarily during vacation periods), or
- (5) The date all Dependent coverage is discontinued under the Plan, or
- (6) The date the Employee ceases to be included in the class of Employees Eligible for Dependent coverage, or
- (7) For Dependent Students under age 25, coverage will end on the 1st day of the month following graduation, or
- (8) The spouse's coverage with terminate on the date of divorce, legal separation or annulment, or
- (9) The Child's coverage will terminate on the date of their marriage, or
- (10) The last day of the period for which the Employee has made the required contribution, if any, toward the cost of Dependent coverage.

When your coverage terminates under this Plan, you and your Covered Dependents may be eligible to continue coverage under "COBRA". If you or your Covered Dependents continue coverage under "COBRA", their coverage under this Plan will terminate as described under "Continuation of Coverage".

WHEN COVERAGE BEGINS (Retirees)

Retiree Eligibility: A Retiree is eligible to continue coverage under the Plan if the Retiree:

- (1) Meets the definition of Retiree, and
- (2) Elects to continue coverage as a Retiree, and
- (3) Makes the required contribution toward the cost of Retiree coverage.

If the Retiree and/or their Dependents are Eligible for Medicare, they must enroll in Part A and Part B of Medicare in order to receive the full benefits of this Plan.

Retiree Dependents Eligibility: A Retiree's Dependent will continue to be covered for benefits under this Plan if the Retiree elects family coverage at retirement. A Retiree who does not enroll for family coverage at retirement may late enroll a Dependent if a special event qualifies the Retiree for

a Special Enrollment Period. The Retiree must notify Human Resources and enroll for coverage within 31 days of the special event.

WHEN COVERAGE ENDS

(Retirees)

When Retiree Coverage Ends: Retiree coverage ends at the earliest of the following:

- (1) The date the Plan is discontinued, or
- (2) The date the Retiree fails to make the required contribution, or
- (3) The Retiree's death.

When Retiree Dependent Coverage Ends: Retiree Dependent coverage ends at the earliest of the following:

- (1) The date the Plan is discontinued, or
- (2) The last date for which the Retiree paid the required contribution, or
- (3) The date the Dependent no longer qualifies as a Dependent, or
- (4) The date a Retiree's Dependent becomes a Covered Employee under the Plan, or
- (5) The Retiree's death.

When your Retiree coverage terminates under this Plan, you may not re-enroll in the Plan. You and your Covered Dependents may be eligible to continue coverage under "COBRA". If you or your Covered Dependents continue coverage under "COBRA", their coverage under this Plan will terminate as described under "Continuation of Coverage".

WHEN COVERAGE BEGINS

(Surviving Spouse and Surviving Dependents)

Your Surviving Spouse and your Eligible Dependents who are Covered at the time of your death may be Eligible to continue coverage on:

- (1) The Adoption Date of this Plan if he was Covered under the Prior Plan as a Surviving Spouse or Dependent, or
- (2) The death of the Covered Employee, if the Surviving Spouse elects to continue coverage under the Plan within 90 days of the Change in Status and makes the required contribution, if any, toward the cost of coverage.
- (3) The death of the Covered Surviving Spouse, if the Surviving Dependent elects to continue coverage under the Plan within 90 days of the Change in Status and makes the required contribution, if any, toward the cost of coverage.

Dependents who are Covered at the time of the Employee's death can continue coverage together with the Surviving Spouse. A Surviving Spouse's new spouse or such spouse's dependent children are not Eligible for coverage under this plan.

WHEN COVERAGE ENDS
(Surviving Spouse and Surviving Dependents)

Coverage under this Plan will terminate for a Surviving Spouse and any Covered Dependents on the earliest of the following:

- (1) The date the Plan is discontinued, or
- (2) The last day of the period for which the Surviving Spouse makes any required contribution for coverage, or
- (3) The Surviving Spouse's date of death.

When Surviving Spouse coverage terminates under this Plan, your Surviving Spouse and Covered Dependents may be eligible to continue coverage under "COBRA". If your surviving Dependents continue coverage under "COBRA", their coverage under this Plan will terminate as described under "Continuation of Coverage".

ELIGIBILITY DURING PERIODS OF DISABILITY, LAYOFF OR LEAVE OF ABSENCE

Employees must check with the Plan Administrator for the Plan's rules regarding continuing eligibility as a Covered Family Member during these periods.

OBLIGATION TO PROVIDE INFORMATION

The Employee must give the Plan Administrator information necessary to determine initial and continuing eligibility status. This information must be provided within 30 days of request. The Plan Administrator has a right to verify this information.

NOTIFICATION OBLIGATION

The Employee must immediately notify the Plan Administrator of any event that affects their eligibility. Such events include, but are not limited to, divorce or annulment, death of a spouse, Medicare eligibility or coverage under another contract, policy or certificate, a Child marrying or reaching the age at which eligibility terminates, and a change or termination of any medical child support order.

CONTINUATION OF COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 - COBRA FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA) UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

This section contains a brief explanation of the Federal laws that permit a Covered Family Member to continue coverage under the Plan. If you lose coverage under the Plan, contact the Plan Administrator at the address and telephone number in the section entitled "General Plan Information". The Plan Administrator is available to provide a complete description of your right to continue coverage under COBRA, FMLA, or USERRA. Coverage will be identical to that provided by the Plan. Proof of good health is not required in order to continue coverage.

Eligible COBRA Beneficiaries: An Employee or any Covered Family Member who loses coverage under the Plan will be considered an Eligible COBRA Beneficiary unless the Employee was terminated due to gross misconduct. An Eligible COBRA Beneficiary includes a new Dependent or a Child who is born or placed for adoption with a COBRA Beneficiary. The new Dependent may be enrolled during the Special Enrollment Period by timely notifying the Plan Administrator.

If an Employee loses Plan benefits due to termination of employment or a reduction in hours, Covered Family Members may continue coverage for up to 18 months by paying the cost of coverage plus any additional amounts set by law. A COBRA Beneficiary may change coverage (individual or family) as described in the subsection entitled "Eligibility And Participation".

A COBRA Beneficiary may be determined totally disabled under Title II or Title XVI of the Social Security Act after enrolling for COBRA coverage. If the Social Security Administration determines that a COBRA Beneficiary was disabled on the date of the qualifying event or within the first 60 days of COBRA coverage, the disabled COBRA Beneficiary and Family Members who are receiving COBRA coverage in connection with the same qualifying event may continue coverage for up to 29 months by paying the cost of coverage plus any additional amounts set by law. The disabled COBRA Beneficiary must apply for and be approved for Social Security Disability benefits. Family Members who are not disabled may elect to extend coverage even if the disabled COBRA Beneficiary declines to do so. Notify the Plan Administrator by mailing a copy of the Social Security determination to the address in the section entitled "General Plan Information". The disabled COBRA Beneficiary must notify the Plan Administrator within 60 days of the Social Security determination and before the end of the 18-month COBRA period.

When a Dependent is Eligible for COBRA: A Covered Dependent becomes an Eligible COBRA Beneficiary if they lose coverage under the Plan. A Covered Dependent can continue coverage up to 36 months if one of the following qualifying events occurs:

- (1) A Child is no longer Eligible as a Dependent (or Dependent Student). The Covered Family Member must notify the Plan Administrator within the later of 60 days of this qualifying event or 60 days of the loss of coverage.
- (2) A spouse is no longer Eligible as a Dependent because of a legal divorce, legal annulment, or legal separation. The Covered Family Member must notify the Plan Administrator within 60 days of this qualifying event.
- (3) An Employee dies. The Employer is responsible for notifying the Plan Administrator no later than 30 days after this qualifying event.

- (4) An Employee becomes enrolled in Medicare while Covered by COBRA. The Employer is responsible for notifying the Plan Administrator no later than 30 days after this qualifying event.

If a second qualifying event described above occurs during the first 18 months of COBRA coverage, the maximum period of continued coverage will be 36 months from the date of the original qualifying event. If you fail to notify the Plan Administrator within 60 days of a Change in Status that causes a Dependent to lose Eligibility (qualifying events 1 and 2 above) the Covered Family Member will lose all rights to continue coverage as an Eligible COBRA Beneficiary.

When Coverage may not be Continued: An Employee or other Covered Family Member who loses coverage when an Employee terminates Active Service due to gross misconduct may not continue coverage under COBRA. The Plan Administrator will send a written notice to the Employee and any other Covered Family Member to explain why the Family Members are not Eligible to continue coverage.

When Continued Coverage Ends: Continued coverage will end for any person when:

- (1) The cost of continued coverage is not paid when it is due, or
- (2) That person becomes enrolled in Medicare after their COBRA election date under this Plan, or
- (3) That person becomes covered under any other health plan after their COBRA election date under this Plan, except one that contains a Pre-Existing Condition provision, or
- (4) The Plan terminates for everyone, or
- (5) The maximum period of extension under this provision ends (18, 29, or 36 months).

If the period of continued coverage was extended from 18 to 29 months due to a person's entitlement to Social Security disability, coverage for that person and for all COBRA Beneficiaries who were entitled to the disability extension will end as of the first of the month beginning 30 days after the date the Covered Family Member is no longer disabled. The person receiving extended coverage as a disabled COBRA Beneficiary is responsible for notifying the Plan Administrator (within 30 days of the Social Security determination) that he or she is no longer disabled.

When continued coverage terminates earlier than the 18, 29, or 36 months described above, the Plan Administrator will send a written notice to any Covered Family Member to explain why COBRA coverage terminated early.

Notice Requirements: If an Employee becomes eligible for COBRA, the Plan Administrator will notify each Covered Family Member of their right to continue coverage and the cost. The Plan Administrator will also notify each Covered Family Member of their right to continue coverage and the applicable cost in the event of an Employee's death or enrollment in Medicare.

Each Covered Family Member has an independent right to elect COBRA coverage, even if an Employee rejects COBRA coverage. The Employee or Covered Family Member must request continued coverage within 60 days from the date they are provided written notice of their eligibility to elect COBRA continued coverage. Any election (or rejection) of continued coverage may be changed for any reason during the 60-day election period. Failure to elect COBRA during the 60-day election period will result in the loss of all rights to continue coverage for the benefits available under this Plan.

If a spouse loses coverage due to a divorce, legal annulment, or legal separation or if a Child loses coverage because the Child no longer qualifies as a Dependent, the Employee, spouse or Dependent must notify the Plan Administrator within 60 days of the Change in Status if they wish to continue coverage. Notify the Plan Administrator at the address in the section entitled "General Plan Information". Failure to notify the Plan Administrator within 60 days of the Change in Status will result in the Covered Family Member losing all rights to continue coverage under this Plan.

It is very important to keep the Plan Administrator informed of the current address of all participants and beneficiaries who are or may become qualified COBRA Beneficiaries. You may notify the Plan Administrator at the address in the section entitled "General Plan Information".

The Employer is required to notify the Plan Administrator of the following qualifying events:

- (1) The Employee's loss of coverage due to termination of employment, other than by reason of gross misconduct.
- (2) An Employee's loss of coverage due to a reduction in hours.
- (3) The death of the Employee.
- (4) The Employee's entitlement to Medicare.
- (5) The commencement of a bankruptcy proceeding with respect to the Employer.

Cost of Continued Coverage: Any person who elects to continue coverage under the Plan must pay the full cost of the coverage plus any additional amounts set by law. If election is made after the Covered Family Member becomes eligible for COBRA, the first payment must reach the Employer within 45 days of the election. It must cover the entire period prior to the election. There is a 30-day grace period allowed for subsequent payments. The cost of the continued coverage will be determined by a method defined by law. Calculation of COBRA premiums is made annually and may increase or decrease based on Plan experience.

Pre-Existing Conditions: Coverage can be continued under this Plan for any period of time that there is no coverage under another health plan due to a Pre-Existing Condition exclusion. If the Pre-Existing Condition limitation contained in the other health plan does not apply or the terms of the limitation have been satisfied, COBRA coverage under this Plan will be terminated, provided that the Covered Family Member became covered under the other health plan after his COBRA election date under this Plan.

Trade Act of 2002: An Employee whose loss of coverage qualifies for the Health Coverage Tax Credit will receive assistance with the cost of continued coverage. The loss of job must be due to trade-related reasons certified by the Department of Labor under the Trade Act of 2002.

Employees who qualify for assistance under the Trade Act of 2002 will also qualify for a second 60-day period to elect COBRA continuation coverage if the Employee is determined to be eligible for trade adjustment assistance after they lose coverage. The second 60-day election period will begin on the first day of the month in which a worker becomes eligible for federal trade adjustment assistance but the election period may not extend beyond six months after the initial loss of group health plan coverage.

If an Employee elects COBRA coverage during the second election period, coverage will begin on the first day of that second election period. There is no retroactive COBRA coverage for the gap between the initial loss of coverage and the first day of the second election period.

The second COBRA election period does not extend the original COBRA benefit period, which is still measured from the date of the loss of coverage due to the qualifying event.

If you have any questions about the Trade Act, you may call the Health Coverage Tax Credit Consumer Contact Center at (866) 628-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

FMLA and USERRA Continuation Coverage: If an Employee is on a leave of absence because of the Family and Medical Leave Act of 1993 (FMLA) or if an Employee is absent from Active Service by reason of “service in the uniformed services,” within the meaning of Section 4303(13) of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Employee may elect continued coverage for a specified period of time. For more information on FMLA or USERRA continuation coverage contact your Employer.

COORDINATION OF BENEFITS

This coordination of benefits provision applies to the payment of benefits provided in this Plan and an Other Plan. If you and your Dependents are covered under more than one health plan, the plans will coordinate the payment of benefits.

The Covered Family Member will receive the maximum benefit allowed including Coinsurance, Copayments and deductibles. The calculation of benefits payable for an Allowable Expense will be made by the Claim Administrator based on the Reasonable and Customary charge, any scheduled benefit, or by reviewing any negotiated (including preferred provider) fee schedules. The following rule will apply whenever a determination of an Allowable Expense must be made under this section:

- (1) When one plan determines an allowable expense by means of a reasonable and customary charge and the Other Plan(s) determines it by a different means, an allowable expense will be determined by the plan that is determined to be primary under this section.
- (2) When both plans determine an allowable expense by the same means (as a reasonable and customary charge or by means of the same schedule mentioned below) the determination of an allowable expense will not include any amount in excess of:
 - (A) Both plans' highest reasonable and customary charge, or
 - (B) Both plans' highest scheduled benefit, or
 - (C) Both plans' highest negotiated (preferred provider) fee schedule.

The Claim Administrator will calculate any benefit payable to a Covered Family Member based on the per claim method. Under this method for coordination of benefits, the maximum benefit payable to the Family Member for Covered Services is limited to 100% of the Allowable Expense on a per claim determination basis.

When Coordination of Benefits Applies: The plans coordinate the payment of claims for benefits and one of the plans pays the claim as the primary plan and the Other Plan pays the claim as the secondary plan. The primary plan pays benefits first. The secondary plan then coordinates the

payment of the claim for benefits, up to the total Allowable Expense. No single plan will pay more than it would have paid without the coordination of benefits provision. A plan that has no coordination of benefits provision is automatically the primary plan.

When this Plan is determined to be the primary plan, the benefits of the Other Plan will be ignored for the purpose of determining the benefits payable under this Plan.

When this Plan is determined to be the secondary plan, the Claim Administrator will determine what expense is an Allowable Expense. Benefits payable under the Other Plan include the benefits that would have been payable had a claim been made for them. Under no circumstance will this Plan pay more than would have been paid had this Plan been the primary plan.

The coordination of benefit calculation will be made for each claim. No recalculation of benefits will be made for charges included in a prior claim.

The plan primarily responsible for payment of benefits is determined in the following order:

- (1) A plan that does not contain a coordination of benefits provision pays first.
- (2) Benefits available through state-mandated automobile fault, no-fault or tort insurance are primary over any benefits payable under this Plan.
- (3) The plan that covers a person as an active employee is primary over a plan that covers that person as a retired employee, COBRA beneficiary, or dependent.
- (4) The Plan that covers a person as a retired employee:
 - (A) Is primary over the plan covering that person as a COBRA beneficiary or dependent, or
 - (B) If eligible for Medicare, the Medicare Secondary Payer (MSP) rules are controlling. This means that the primary plan is the plan covering the person as a dependent of an active person, Medicare would be secondary, and the retiree plan would pay last unless a superceding Medicare Secondary Payer rule would control.
- (5) Except as stated in paragraph (6) below, if this Plan and an Other Plan cover the same child as a dependent of different persons called "parents," the plan of the parent whose birthday falls first in the year will be primary over the plan of the parent whose birthday falls second in the year. Birthday means month and day, not the year. If both parents have the same birthday, benefits for the plan that covered a parent longer are determined before those of the plan that covered the other parent for a shorter period of time. This also applies when the parents are not divorced or legally separated, whether or not they have ever been married.
- (6) If two or more plans cover a person as a dependent child of divorced or separated parents, whether or not the parents were ever married, benefits for the child are determined as follows:
 - (A) First, the plan of the custodial parent of the child;
 - (B) Second, the plan of the spouse of the custodial parent of the child;
 - (C) Third, the plan of the non-custodial parent of the child;
 - (D) Last, the plan of the spouse of the non-custodial parent of the child.
 - (E) However, if the terms of a Qualified Medical Child Support Order (QMCSO) or other court order state that one of the parents is responsible for the health care expenses of the child, the benefits of that plan are determined first. When the specific terms of a QMCSO state that the parents shall share joint custody, but do not specify which parent has financial responsibility for the health care expenses of the child, the Plan will

determine primary coverage by the birthday rule. If the responsible parent named in the QMCSO does not have health care coverage for the dependent child, but that parent's spouse does have coverage for that child, then the spouse's plan will be primary.

- (7) When the above rules do not establish an order for the coordination of benefits, the plan that covered the person longer will be primary.

When a claim is submitted on behalf of any Covered Family Member, the Claim Administrator will need all information about any Other Plan providing coverage. The Claim Administrator has the right to release or obtain any related information and make or recover any payments it considers necessary to administer these provisions.

When medical coverage under an Other Plan is primary and the coverage under this Plan is secondary, submit any claim to the Other Plan first. Then, submit a copy of the "explanation of benefits" from the Other Plan when submitting the claim to the Claim Administrator of this Plan.

Effect on Benefits: If this Plan pays less than it would otherwise pay due to this coordination of benefits provision, only the reduced amount is applied to any maximum benefit limit described in the Schedule of Benefits. This Plan will not consider any charge in excess of what an HMO Provider or Preferred Provider has agreed to accept as payment in full.

Continuation of Coverage: A Covered Family Member may elect continuation of coverage under a right of continuation according to Federal law and also have coverage under an Other Plan. When coordination of benefits applies, the benefits of a plan that covers the Family Member as an employee, subscriber or retiree (or as the Dependent of that Family Member) will be determined first. The benefits under continuation of coverage will be determined second.

When a Managed Care Plan is the Primary Plan: If a managed care plan or health maintenance organization (HMO) Plan is the primary plan for a Covered Family Member and the Family Member elects to ignore its provisions, exclusions, or limitations, or chooses to go outside the Other Plan for treatment, this Plan will not accept liability or coordinate benefits for the charges not covered by the Other Plan.

Right to Receive and Release Necessary Information: The Claim Administrator has the right to receive or release any information considered necessary to administer these coordination of benefits provisions.

Right of Recovery: When the Plan pays benefits that should have been paid by an Other Plan, this Plan's Claim Administrator may recover any amount paid, either from the Other Plan or from the Covered Family Member. That recovery will count as a valid payment under the Other Plan.

When it is determined that an overpayment was made, the Claim Administrator may recover the overpayment from the source to which it was paid. An overpayment is any benefit payment that exceeds the Allowable Expense.

THE EFFECT OF MEDICARE

The Plan will determine Medicare related benefits according to the provisions in this section when a Covered Family Member is eligible for Medicare.

Eligibility for Medicare: A Covered Family Member is eligible for Medicare when:

- (1) The Covered Family Member has coverage under Medicare, or
- (2) The Covered Family Member qualifies for coverage under Medicare, but has refused, discontinued, or failed to apply for Medicare coverage.

The Effect of Medicare Secondary Payer Rules: The Medicare Secondary Payer Rules require that this Plan be the primary payer of benefits for the following Covered Family Members who are also eligible for Medicare:

- (1) A Covered Employee in Active Service, including any individual on short term or long term disability for up to six months while that individual is an Employee, and
- (2) The Covered Dependent of an Employee in Active Service if the Dependent is also covered by Medicare.

This Plan will be the primary payer of medical expense benefits for a Covered Family Member who is also covered by Medicare unless the Employee or Dependent chooses to terminate coverage under this Plan and elects Medicare as the primary payer of medical expense coverage. But if the Employee elects Medicare as the primary payer of medical expense coverage, the Employee's medical benefits under this Plan will cease. If a Covered Dependent elects Medicare as the primary payer of medical expense coverage, the Dependent's medical benefits under this Plan will cease.

If an Employee is eligible for Medicare prior to becoming eligible for COBRA coverage, Medicare will be the primary payer.

When a Covered Family Member is eligible for Medicare due to end stage renal disease (ESRD) this Plan will be the primary payer for the first 30 months unless the Covered Family Member was already entitled to Medicare on the basis of age or disability and no other Medicare secondary payer rule applies. Medicare will be the primary payer of benefits after the first 30 months.

Regardless of any other provisions of this section, the Plan will be secondary to Medicare to the extent permitted by applicable law, and under no circumstances will the Plan pay more than its regular benefit.

When Medicare is the Primary Payer: When Medicare is primary payer of medical expense benefits the amount of health expense benefits payable will be calculated using the per claim coordination of benefits method.

This means the Plan will coordinate benefits with Medicare being the primary payer and this Plan's benefits will be secondary to Medicare benefits on a per claim basis. Any expense that is not covered by Medicare but is a Covered Service under the Plan will be determined according to the provisions of the Plan.

When Medicare does not pay a claim because the Covered Family Member refused, discontinued, or failed to apply for Medicare coverage, the Claim Administrator will estimate the amount of benefit

Medicare would have paid on a non-discriminatory basis. The Claim Administrator's estimate will be used to determine the amount of any benefit payable for a Covered Service under this Plan.

Any benefits payable as calculated above will be determined before benefits are coordinated with any Other Plan. A benefit calculation will be made for each claim. No recalculation of benefits will be made for charges included in a prior claim based on that prior calculation of benefits.

Medicare Assignment: Assignment is an agreement between Medicare, physicians, suppliers and other health care providers who agree to accept the Medicare approved amount as payment in full for services. The Medicare Covered Family Member is only responsible to pay the Medicare deductible and coinsurance amounts. Physicians, suppliers and other health care providers who have agreed to accept assignment from Medicare are not permitted to bill or collect from the Medicare Covered Family Member an amount that is over Medicare's approved amounts. This Plan will not cover any services in excess of the Medicare approved amount.

Some physicians, suppliers and other Health Care Providers do not accept Medicare assignment. Federal law limits the charges Medicare will reimburse when certain Providers refuse assignment to 15% over the Medicare-approved amount (called a limiting charge). When a limiting charge is applied to a Provider who does not accept Medicare assignment, the Provider is not allowed to bill or collect from the Covered Family Member any amount that is over the Medicare limiting charge. This Plan will not reimburse those Providers for any Covered Service in excess of Medicare's limiting charge.

Medicare Advantage Plan: Medicare offers a managed care program alternative to the traditional Medicare coverage called Medicare Advantage, or Medicare Part C. Medicare eligible Covered Family Members can choose to either remain in Medicare Parts A and B, or they can elect coverage under Medicare Advantage through an approved network of health care providers. If Medicare Advantage is elected, the Covered Family Member's care will be managed by that approved network. All treatment must be provided through the Medicare Advantage network.

If the Covered Family Member elects to receive services outside of the Medicare Advantage network, the expenses related to those unauthorized services will not be covered under this Plan.

A Covered Family Member who elects the Medicare Advantage plan will receive a membership card with the name of the Medicare Advantage network. A member of a Medicare Advantage plan can contact the Social Security Administration at the telephone number listed on their identification card to verify the name of their network.

SUBROGATION/REIMBURSEMENT PROVISION

The Plan does not provide any coverage with respect to any accident, Sickness or Injury for which any party may be liable or legally responsible. If a Covered Member receives or expects to receive any payment from any source for expenses resulting from such accident, Sickness or Injury, you should not submit a claim for benefits under this Plan. Any such recovery will be deemed as compensation for medical expenses. Payment made by the Plan for any such accident, Sickness or Injury would be considered an overpayment and the Plan will seek reimbursement for such overpayment. The Plan, at its discretion, may authorize Plan benefits for expenses that would otherwise be covered by the Plan. Any such payments are subject to the Plan's subrogation or

reimbursement rights.

The Covered Member is required to notify the Plan Administrator within 10 days of any accident, Sickness or Injury for which someone else may be liable. The Plan Administrator must also be notified within 10 days of the initiation of any lawsuit arising out of the accident, Sickness or Injury and the conclusion of any settlement, judgment or payment relating to the accident, Injury, or Sickness in any lawsuit to protect the Plan's claims.

Subrogation Right: Subrogation conserves Plan benefits by keeping a Covered Member from profiting by a double recovery for a Covered Service. As a condition for receipt of benefits under this Plan, Covered Members must agree to promptly reimburse the Plan first, before any other party is paid, if a Covered Member recovers any money damages for the accident, Sickness or Injury regardless of how the recovery is characterized, including damages for malpractice, from any other party on account of such accident, Sickness or Injury. The Plan Administrator has, to the extent of the full cost of any Covered Service paid under this Plan, a subrogated right to the Covered Member's recovery from such party.

The reimbursement required under this provision:

- (1) Applies even if the total recovery is less than the losses incurred as a result of the accident, Sickness or Injury suffered by the Covered Member has been fully compensated, or "*made whole*", by their recovery. This Plan specifically rejects the application of the made whole doctrine, and
- (2) Will not be reduced to reflect any of the costs of attorney's fees and disbursements incurred in obtaining such judgment or settlement, unless separately agreed to, in writing, by the Plan Administrator in the exercise of its sole discretion, and
- (3) Applies regardless of whether such funds are earmarked for pain and suffering or any other form of non-economic loss.

Conditional Benefit Payment: The Claim Administrator may provide benefits when a Covered Member receives a Covered Service. However, before such benefits are conditionally made, the Covered Member will be required to execute and timely deliver such documents or take such other action as is necessary to fully assure the rights and remedies of the Plan Administrator.

This right of subrogation allows the Plan to pursue any claims which the Covered Member has against any party, or insurer, whether or not the Covered Member chooses to pursue that claim.

The failure or refusal of the Covered Member to cooperate with and assist the Plan in pursuit of its right to subrogate any party claims may result in the forfeiture and termination of his entitlement to continue coverage under this Plan.

Subrogation under this section specifically does not apply to an individual health insurance policy that the Covered Member may have in force.

Subrogation Agreement: Once it has been determined that any party may be liable in any way for the accident, Sickness or Injury you are required to provide in writing any expense for which any party may be liable. The Covered Member, authorized representative if a minor or unable to sign, or his or her legal representative, must execute and provide timely delivery of documents, notices or papers as may be required and must do whatever else is needed to secure the rights of the Plan, including the following:

- (1) The Covered Member or legal representative must agree, in writing, to provide the Claim Administrator with written notice whenever a claim is asserted or could be asserted against, and/or receipt of funds from any party for damages as the result of accident, Sickness or Injury, and
- (2) The Covered Member or legal representative must agree, in writing, on a form acceptable to the Claim Administrator, to reimburse the Plan at 100% for any benefits, past, present or future, paid on your behalf for any such accident, Sickness or Injury. This reimbursement can be from any settlement, judgment, or other payment that you obtain from the liable party, before any expenses are taken out, including but not limited to, attorney's fees and court costs, and
- (3) The Covered Member or legal representative of a minor Dependent must provide, in writing, an assignment of benefits or a lien against such proceeds, in favor of the Plan in the amount of any benefits paid by the Plan due to such accident, Sickness or Injury. The assignment of benefits will be valid against any judgment, settlement, or recovery that is or will be received from any party, and
- (4) The Covered Member receiving benefits further agrees that any funds received by the Covered Member or their attorney, if any, from any source for any purpose shall be held in trust until such time as the obligation under this provision is fully satisfied, and
- (5) The Covered Member will be responsible for the Plan's court costs and attorney's fees if the Plan needs to file suit to recover payments of expenses previously paid by the Plan.

UTILIZATION MANAGEMENT AND MEDICAL REVIEW

Primary Care Physicians and Referral Management: The Broome County Red HMO Medical Plan is an HMO plan design that provides comprehensive care through an established network of physicians, hospitals and other providers. When Covered Family Members enroll, each participant must choose a Primary Care Physician (PCP) from the Preferred Provider Network. Covered Family Members may change their PCP at any time by calling the phone number on their benefit identification card. This must be done prior to receiving services or benefits will be denied.

This Plan requires referrals or Prior Authorization from the PCP for additional services including the care of a specialist. The PCP may obtain a referral or Prior Authorization by calling the toll-free number on the back of the Covered Family Member's benefit identification card. If the Covered Family Member does not obtain a referral for additional services, benefits will be denied. When obtaining a referral or Prior Authorization for a hospital admission, surgery or other treatment that includes ancillary services such as anesthesia, radiology and pathology, the PCP is only required to

Pre-Authorize the admission or the main procedure, not the ancillary services. The following services do not require a PCP referral:

- (1) Emergency services; however, the Covered Family Member must get a referral from their PCP for follow-up care.
- (2) Obstetric and gynecological services.
- (3) Routine eye exams.

Prior Notice: Prior notice means the notice your Provider must give to the Medical Services Team before the Covered Family Member can get certain Covered Services. The Medical Services Team does not review, approve or deny benefits at that time. Prior notice is required on the following services:

- (1) Elective inpatient services;
- (2) Surgical procedures (except office surgeries);
- (3) Non-Emergency ambulance services;
- (4) All outpatient Mental Illness services.

Pre-Certification: The process by which the Plan's Medical Services Team evaluates a Pre-Service Claim is defined as Pre-Certification. A Covered Family Member must Pre-Certify the following Covered Services:

- (1) Transplant services;
- (2) Certain elective surgical procedures (see list below*);
- (3) Advanced infertility treatment;
- (4) Inpatient Mental Illness services;
- (5) Hospice care;
- (6) Home health care;
- (7) Convalescent/Skilled Nursing Facility services;
- (8) Speech therapy;
- (9) Durable Medical Equipment, prosthetics and orthotics exceeding \$500.

***The following surgical and imaging procedures require Pre-Certification**

Diagnostic laparoscopy	Gastric bypass surgery/gastroplasty
Lumbar laminectomy (discectomy);	Blepharoplasty
Hysterectomy;	Breast implantation
Septoplasty	Breast reduction
Sinus surgery	Cochlear implant
Spinal fusion	Oral surgery/orthognathic surgery
Cataract surgery	Rhinoplasty
Hammer toe surgery	MRI/MRA, CAT, PET Scans
Hemorrhoidectomy	Nuclear cardiology
Shoulder arthroscopy	

If utilizing non-participating providers, the member is responsible for notifying RMSCO Medical Management at least 10 days prior to the service.

The certification process attempts to determine, in advance, the Medical Necessity of the services and the proposed length of stay. A second medical opinion may be used to approve the confinement, if necessary.

Whenever a physician recommends confinement or one of the above services, the Covered Family Member, the physician or an Authorized Representative must contact the Medical Services Team. A toll-free number is on the back of the Covered Family Member's benefit identification card. If a Covered Family Member is admitted because of an Emergency, the Medical Services Team must be notified within 48 hours.

Note: The Pre-Certification requirement is waived when Medicare is the primary carrier. Pre-Certification is not required on MRIs, MRAs, CAT scans, and PET scans when performed in the Emergency room.

A Pre-Service Claim will be reviewed within a reasonable period of time, but no longer than 15 days after receiving the request. The Medical Services Team will notify, in writing, the Covered Family Member or Authorized Representative, the physician, and the Hospital whether or not the Pre-Service Claim has been approved. Requests involving Urgent Care will be reviewed within the time limits described in the section entitled "Determination of Benefits".

Inpatient Maternity Care: Pre-Certification is recommended but is not required for admissions for childbirth. Post-Certification is required in the event an admission for childbirth, including a Hospital stay for the newborn, exceeds 48 hours following a normal delivery or 96 hours following a cesarean section delivery. The Covered Family Member must contact the Medical Services Team within 24 hours or the next business day to certify the additional confinement. The Medical Services Team must be notified within 48 hours of an Emergency admission to a Hospital in connection with pregnancy but not delivery.

Concurrent Stay Review: Concurrent stay review is the process by which the Medical Services Team evaluates the attending physician's request for confinement which continues longer than what was originally Pre-Certified and approved. The Covered Family Member or an Authorized Representative must notify the Medical Services Team of such Concurrent Claim before the Covered Family Member is discharged. A request to Certify a Concurrent Claim will be evaluated within a reasonable period of time, but no longer than 15 days after receiving the request. The Medical Services Team will notify, in writing, the Covered Family Member or Authorized Representative, the physician, and the Hospital whether or not the Concurrent Claim is certified. Requests involving Urgent Care will be reviewed within the time limits described in the section entitled "Determination of Benefits".

Penalty for Non-Compliance: Benefits will not be available under this Plan if a Covered Family Member:

- (1) Fails to Pre-Certify one of the services listed, including Emergency admissions, in the subsection entitled "Pre-Certification", fails to obtain prior notice for one of the services listed in the subsection entitled "Prior Notice", or does not obtain a referral from their PCP for additional services, including, but not limited to, visits to a specialist, or
- (2) Remains confined longer than what was initially Pre-Certified and does not request certification of the Concurrent Claim, or
- (3) Fails to request Post-Certification for a maternity stay (including a Hospital stay for the newborn) for a delivery that exceeds 48 hours for a normal delivery or 96 hours for a cesarean delivery or within 48 hours of an Emergency admission not related to delivery.

In order to avoid penalties, the Covered Family Member must call the Medical Services Team for Pre-Certification or certification of a Concurrent Claim.

Utilization Management: The Plan Administrator reserves the right to incorporate a utilization management program into the Plan's benefit provisions. If alternative services are recommended which are not specified in the Plan as Allowable Expenses, the Plan Administrator shall have the right to approve reimbursement of such services. Utilization Management means the systems, strategies, and mechanisms needed to manage appropriate, Medically Necessary and cost-effective health care services.

Utilization Management is intended to:

- (1) Assure high quality care and treatment, and
- (2) Propose alternative treatments to avoid unnecessary or lengthy confinements and surgeries, and
- (3) Promote cost-effective health care, and
- (4) Monitor the treatment plan for Covered Family Members with chronic Sickness or catastrophic Injury through medical case management.

When an alternate service involves care at home or is for rehabilitative purposes, the Claim Administrator may provide benefits for the alternate service as an Allowable Expense.

Case Management and Alternate Treatment Provision: In the event of a catastrophic Injury or Sickness, a Covered Family Member may require long-term, perhaps lifetime care. Case Management monitors such patients and explores, discusses and recommends coverage for coordinated and/or alternate types of appropriate Medically Necessary care.

In certain cases, the case manager may recommend coverage of alternative care and/or treatment when Medically Necessary and cost effective. If the alternative treatment plan is approved, the Plan Administrator may direct the Plan to cover Medically Necessary expenses as stated in the alternative treatment plan, even if the Plan would not normally pay those expenses.

DETAILED DESCRIPTION OF BENEFITS

This Plan only makes payment decisions based on the benefits provided. It is the responsibility of the patient and the attending physician to decide whether treatment should be rendered regardless if the services are totally or partially covered, or excluded from coverage under the Plan. The Plan does not and cannot make treatment decisions. The Plan does not select or take any responsibility for the proper or improper performance of any healthcare provided.

Benefits payable under the Plan will be subject to any applicable Coinsurance, Copayments, maximums and deductible amounts, and any limitations as described in the Schedule of Benefits.

HEALTH MAINTENANCE ORGANIZATION PROGRAM

This Plan requires referrals or Prior Authorization from the PCP for additional services including the care of a specialist. The PCP may obtain a referral or Prior Authorization by calling the toll-free number on the back of the Covered Family Member's benefit identification card. When obtaining a referral or Prior Authorization for a hospital admission, surgery or other treatment that includes ancillary services such as anesthesia, radiology and pathology, the PCP is only required to Pre-Authorize the admission or the main procedure, not the ancillary services. The following services do not require a PCP referral:

- (1) Emergency services; however, the Covered Family Member must get a referral from their PCP for follow-up care.
- (2) Obstetric and gynecological services.
- (3) Routine eye exams.

The Claim Administrator will pay benefits directly to the Provider for Covered Services less any applicable Coinsurance, deductible, or Copayment. If you or your Covered Dependent seeks care or treatment from a provider who is not a member of the Preferred Provider Network or does not obtain a referral for additional services, medical expense benefits will be denied. If a non-participating provider must be utilized, the Covered Family Member or referring provider is responsible for notifying RMSCO Medical Management at least 10 days prior to the service. Otherwise, benefits will be denied.

Due to changes that may occur in the participation status of the Provider, it is the responsibility of the Employee to verify that the Provider is still a Participating member. A list of Preferred Providers is available from your Employer, or via the Internet at www.rmscoinc.com.

Dependent Student Coverage: While an unmarried Dependent Student (as defined by the Plan) is a full-time student at an accredited college or university, the student may receive certain Covered Services not provided by a Preferred Provider as described below:

- (1) For elective outpatient surgery and specialty care, the Dependent Student is not required to access care through his or her PCP. If the Dependent Student wishes to obtain these services without PCP involvement, then the Dependent Student must obtain authorization from the Medical Services Team prior to receiving the services. Upon receipt of a claim for these services, the Medical Services Team will notify the Dependent Student's PCP to update the Dependent Student's medical record.

- (2) Female Dependent Students may self-refer to a qualified Preferred Provider for primary and preventive obstetric and gynecological care.
- (3) Emergency services are covered as described elsewhere in this Plan Document.
- (4) Preventive care, including, but not limited to, well child care, physical examinations and immunizations, and elective inpatient hospital services are covered as described elsewhere in this Plan Document and must be arranged by the Dependent Student's PCP.
- (5) For services arranged by the Dependent Student's PCP, the Dependent Student is responsible for the applicable Copayment.
- (6) For services not arranged by the Dependent Student's PCP and not otherwise covered, the Dependent Student is responsible for the entire cost of the services including the applicable Copayment. Coverage for services provided by a non-Preferred Provider, together with services provided by a Preferred Provider that were not arranged by the Dependent Student's PCP, is limited to \$2,500 per year.
- (7) For services provided in Paragraph 6 above, the Plan will reimburse the Dependent Student for the Usual and Customary cost of services minus the applicable Copayment after the Dependent Student submits properly completed claim forms. Claims should be submitted as soon as possible. The Dependent Student will not be reimbursed for claims filed later than one year after the date of service.

MEDICAL EXPENSE BENEFITS

The Plan will pay benefits for Medically Necessary Covered Services subject to any applicable Coinsurance, Copayments, maximums and deductibles, and any limitations, as shown in the Schedule of Benefits and elsewhere in this Plan Document.

Allowable Expenses are identified by codes as indicated in the Current Procedural Terminology (CPT) manual developed by the American Medical Association, HCFA-1450 (UB-92), or the Common Procedure Coding System (HCPCS) developed by the Health Care Financing Administration. Covered Medical conditions are identified in the International Classification of Diseases, 9th edition (ICD-9). Covered Services include:

- (1) **Allergy Care.** The Plan covers allergy treatment including, but not limited to, office visits, serum, scratch testing, and laboratory testing. Allergy serum that is covered under the Prescription Drug Expense Benefit will not be covered as a Medical Expense Benefit.
- (2) **Ambulance and Paramedic Services.** The Plan covers Medically Necessary non-airborne ambulance or paramedic services in connection with an inpatient confinement or outpatient Emergency treatment to the nearest appropriate facility. Ambulance service used to transport a Covered Family Member from a Hospital or other health care facility or to inpatient confinement at another Hospital or health care facility and home is also covered when Medically Necessary.

The Medical Services Team must be Pre-Notified of all non-Emergency ambulance services as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Notify may result in a penalty.

Ambulance and Paramedic Limitations and Exclusions: Air ambulance is not covered. Transport is limited to Medically Necessary transportation by an ambulance. The ambulance must be licensed by the State in which it operates.

- (3) **Anesthesia.** The Plan covers anesthesia and its administration.
- (4) **Biofeedback Treatment.** The Plan covers Medically Necessary biofeedback treatment for the treatment of urinary incontinence only.
- (5) **Blood, Blood Products and Blood Transfusions.** The Plan covers blood, blood products (including plasma and derivatives) and blood transfusions. The Plan also covers blood donation expenses for Covered Family Members who wish to donate their own blood for their own upcoming surgery or procedure.
- (6) **Cardiac Rehabilitation.** The Plan covers services for cardiac rehabilitation rendered at a Hospital or freestanding cardiac rehabilitation center. Services must be Medically Necessary due to certain medical conditions, including, but not limited to, post heart transplants, dilated cardiomyopathy, post myocardial infarction, post bypass surgery or angioplasty.

Cardiac Rehabilitation Exclusions and Limitations: This benefit is limited to expenses for telemetric monitored exercise for cardiac rehabilitation only. No other exercise programs are covered. Related testing procedures and physicians exams will be considered separately.

- (7) **Chemotherapy and Radiation Therapy.** The Plan covers chemotherapy and radiation therapy.
- (8) **Chiropractic Care.** The Plan covers the services of a chiropractor for the treatment of acute care only. Covered Services include the detection and correction, by manual or mechanical means, of misalignment or subluxation of the vertebral column.

Chiropractor Limitations and Exclusions: Therapy performed to stabilize a chronic condition or prevent deterioration is not covered. Maintenance therapy that seeks to prevent disease, promote health, prolong life, and enhance the quality of life is not covered.

- (9) **Convalescent/Skilled Nursing Facility.** The Plan covers inpatient charges if the confinement starts within 30 days of a Hospital stay or 30 days of another Convalescent/Skilled Nursing or Rehabilitation Facility confinement. The previous inpatient Hospital confinement must have been for a minimum of three consecutive days for which inpatient Hospital expense benefits are payable by the Plan. A plan of treatment must be established by the attending physician and must demonstrate the Medical Necessity of the treatment, including the need for continuous care by a physician and 24-hour-a-day skilled nursing care. The physician must be qualified in the state of jurisdiction to prescribe the plan of treatment recommended, must remain available to visit the patient during the admission and provide the patient continuous care. The physician may not have any financial interest in the Convalescent/Skilled Nursing Facility.

The Plan covers the daily charge for room and board that does not exceed the semi-private rate. If the facility does not have a semi-private room available, the Plan will pay the lowest daily rate for the private room and board charge. Outpatient care for physical, occupational, and speech therapy and other services shown in the Schedule of Benefits is covered.

All care in a Convalescent/Skilled Nursing Facility must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.

- (10) **Diabetic Education.** The Plan covers diabetic self-management education to ensure the Covered Family Member is educated in the proper self-management and treatment of his diabetic condition. Coverage includes home visits when Medically Necessary.

Diabetic Education Limitations and Exclusions: Coverage is limited to visits for the diagnosis of diabetes, when a physician diagnoses a significant change in the Covered Family Member's symptoms or conditions which necessitates changes in the Covered Family Member's self-management, or where reeducation or refresher education is necessary.

The diabetic education must be provided by a physician or other licensed Health Care Provider, or his staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian, upon the referral of a physician or other licensed Health Care Provider.

- (11) **Diagnostic Tests.** The Plan covers diagnostic tests performed both inside and outside a Hospital including, but not limited to, diagnostic laboratory services, diagnostic x-ray tests, diagnostic tests (EKG, EEG, etc.), non-routine mammograms and pap smears, and non-routine prostate specific antigens (PSAs).

All advanced imaging procedures such as MRIs, MRAs, PET scans, and CAT scans must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.

- (12) **Dialysis and Hemodialysis.** The Plan covers dialysis and hemodialysis rendered by a licensed technician.

- (13) **Durable Medical Equipment, Prosthetics, Medical Supplies, and Oxygen.** The Plan covers the following services, subject to review of Medical Necessity and the patient's condition:

(A) **Durable Medical Equipment.** The Plan covers rental, or at the Plan's option, purchase of Durable Medical Equipment. The Plan also covers necessary maintenance, repairs and replacement of purchased Durable Medical Equipment. Maintenance and repairs can be paid on a per session basis or through an approved maintenance agreement.

(B) **Prosthetic Devices.** The Plan covers the fitting and purchase of prosthetic devices that take the place of a natural internal or external part of a Covered

Family Member's body (including, but not limited to, breast prostheses and initial mastectomy bra following a covered mastectomy) or that are needed due to a congenital or functional defect of a Covered Dependent Child. External breast prostheses are covered once every two Calendar Years, if replacement is Medically Necessary.

The Plan covers eye exams, contact lenses or glasses for aphakic patients and cataract patients who do not receive implants, and soft lenses or sclera shells intended for use in the treatment of Sickness or Injury. Coverage will only be provided when necessitated by damage to the natural eye as a result of an Injury as stated above, or a Sickness which results in similar damage. Services must restore or rehabilitate any resulting loss of vision.

- (C) **Orthotics.** The Plan will provide benefits for custom made orthotics (braces), such as an ankle foot orthosis (brace), when prescribed or furnished by a physician, podiatrist, or orthotic specialist.

Orthotics Limitations and Exclusions: The Plan does not pay for orthopedic shoes, lifts, supports, and/or other orthopedic devices to be attached to or worn in shoes, unless such devices or their use is determined to be both: (a) an alternative to surgical correction, or is required due to therapeutic processes, and (b) such devices are custom made and designed solely for the individual requiring the orthopedic device.

- (D) **Medical Supplies.** The Plan covers certain medical supplies for use outside of a Hospital, Convalescent/Skilled Nursing Facility, or a Rehabilitation Facility ordered by a physician such as casts, splints, catheters, ostomy bags, and custom fitted compression garments.

- (E) **Oxygen.** The Plan covers oxygen and the administration of oxygen. When the Plan covers the purchase of equipment used to administer oxygen, the Plan also covers necessary maintenance and repairs.

All Durable Medical Equipment, prosthetics and orthotics exceeding \$500 must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.

Durable Medical Equipment, Prosthetics, Medical Supplies, and Oxygen Limitations and Exclusions: Items used primarily for cosmetic purposes are considered not Medically Necessary. The Plan does not cover the cost of delivery and set up of deluxe equipment when standard equipment is available and adequate, or the cost of materials used to manufacture equipment.

Foot orthotics, inserts or appliances whether or not custom made are not covered under the Plan. Wigs and hairpieces are not covered.

Adjustments, maintenance and repairs to covered devices and medical supplies are covered if necessary due to normal wear or when required by a change in the patient's condition. Covered Services can be paid on a per session basis or through an approved maintenance agreement, unless covered by a manufacturer's warranty

or purchase agreement. The Plan will also cover Medically Necessary loaner equipment used while repairs are being made.

The replacement of a Medically Necessary Covered Service is covered only if:

- (i) The patient has experienced a change in their physiological condition, or
- (ii) Required repairs would exceed the cost of a replacement device or the parts that need to be replaced, or
- (iii) There has been irreparable change in the device's condition or in a part of the device due to normal wear and tear.

- (14) **Freestanding Surgical Facility.** The Plan covers Medically Necessary treatment rendered in a Freestanding Surgical Facility.

The Medical Services Team must be Pre-Notified of all surgical procedures (except for office surgeries) must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Notify may result in a penalty.

- (15) **Home Health Care.** The Plan covers home health care as shown in the Schedule of Benefits if the plan of treatment is established at the time the physician certifies the Medical Necessity of the home health care services. The plan must be filed with the Claim Administrator. The physician may not have any financial relationship with the Home Health Care Agency furnishing the services. The physician must be qualified under the law of the state to certify the need for home health care and the plan of treatment. It is expected that the physician will see the patient although there is no specified time interval for those visits.

A home health care visit is an episode of personal contact with the patient by the staff of the Home Health Care Agency for the purpose of providing a covered home health care service. Each time a Home Health Care Agency employee enters the patient's home to provide a Covered Service to a patient is considered a visit.

Nursing and therapy services authorized as part of a home health care plan and performed by a nurse or therapist affiliated with a Home Health Care Agency are also covered.

All home health care must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.

Home Health Care Limitations and Exclusions: Charges are not covered for care and treatment not outlined by the physician in the home health care plan, or home health care incurred during any period when the Covered Family Member is not under the care of a physician.

- (16) **Hospice Care.** A Covered Family Member diagnosed with a terminal illness and a life expectancy of six months or less may receive care by a certified Hospice Care Agency. Hospice care consists of services and supplies, including prescription drugs, provided by the hospice to the extent they are otherwise covered by this

Plan. Treatment may be furnished in a Hospice Facility or Hospital, or on an outpatient basis in the terminally ill Covered Family Member's home under a home care plan provided by a hospice. The Plan covers charges for respite care. Respite care is intended to provide temporary relief to the family or other caregivers during emergency situations and from the daily demands for caring for the terminally ill Covered Family Member. Inpatient respite care need not meet the normal Medically Necessary criteria for admissions. Hospice care includes bereavement counseling furnished to the family of the terminally ill Family Member by the Hospice Care Agency. Bereavement counseling may be provided before or after the Covered Family Member's death.

All hospice care must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.

Hospice Care Limitations and Exclusions: The Plan does not cover:

- (A) Charges for a physician employed by the Hospice, or
- (B) Any confinement, unless part of respite care, not required for pain control or other acute or chronic system management, or
- (C) Services or supplies provided by volunteers or others who do not regularly charge for their services, including pastoral counseling, or
- (D) Funeral services or arrangements, or
- (E) Legal or financial counseling or services, or
- (F) Services, except bereavement counseling, supplied to other Family Members, other than the terminally ill Family Member.
- (G) Bereavement counseling in excess of five visits, or
- (H) Any expense incurred by a Covered Family Member which is listed in the section entitled "Plan Exclusions".

(17) **Hospital Services.** The Plan covers inpatient and outpatient treatment in the Hospital:

- (A) **Inpatient Hospital Admission.** The Plan covers Hospital miscellaneous expenses and semi-private room and board accommodations. If the Covered Family Member occupies a private room, regardless of the reason, the Plan will only cover that Hospital's most common semi-private room rate and the Covered Family Member will be responsible for the difference in cost.

With respect to a confinement related to a dental procedure, the Plan covers Hospital expenses regardless of whether or not the actual dental procedure is covered. The confinement must be Medically Necessary.

The Medical Services Team must be Pre-Notified of all inpatient admissions to a Hospital (except for delivery) must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Notify may result in a penalty.

Inpatient Hospital Admission Limitations and Exclusions: The Plan does not cover charges for personal items including, but not limited to, telephone, television and guest trays.

- (B) **Outpatient Hospital Treatment.** The Plan covers expenses in the outpatient department of the Hospital. Covered Services include, but are not limited to, outpatient diagnostic testing, chemotherapy, radiation and dialysis.

With respect to outpatient Hospital treatment related to a dental procedure, the Plan covers outpatient Hospital expenses regardless of whether or not the actual dental procedure is covered. The services must be Medically Necessary.

- (C) **Emergency Room Treatment.** The Plan covers Medically Necessary treatment of a medical Emergency in the Emergency room.

Emergency means a sudden onset of symptoms that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably determine that the absence of immediate medical attention would result in serious physical impairment or death. It also means a situation in which a Covered Family Member appears to have a mental or emotional disorder for which immediate observation, care and treatment is necessary to avoid serious harm to the Covered Family Member or others. Emergency treatment must be rendered within 72 hours of an Injury or within 12 hours of onset of a sudden and serious Illness.

A PCP referral is not required for these services.

Emergency Room Treatment Limitations and Exclusions: Medical, dental or Behavioral Health related treatment that does not meet the definition of an Emergency, as defined by the Plan, is not covered.

- (18) **Infertility Treatment.** The Plan covers Medically Necessary diagnostic services and treatment, including artificial insemination, of the Sickness or Injury that is the cause of infertility. Treatment must be rendered on an outpatient basis.

All advanced infertility treatment must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.

Infertility Treatment Limitations and Exclusions: The Plan does not cover any service, except for artificial insemination, that provides assistance in achieving a pregnancy. The following procedures and similar procedures intended to achieve a pregnancy are excluded from coverage under this Plan's Medical Expense Benefit: in-vitro fertilization, in-vivo fertilization, gamete inter-fallopian transfer (GIFT), zygote Inter-fallopian transfer (ZIFT) or similar procedures to achieve a pregnancy.

- (19) **Infusion Therapy.** The Plan covers Medically Necessary treatment by a covered Provider for infusion of antibiotics, chemotherapy, and other infusion therapies in the Covered Family Member's home or Provider's office. Covered Services include:

- (A) Medical care for the patient receiving infusion therapy via central venous line or standard intra-venous route;

- (B) Other infusion therapies, including hydration, antibiotics, chemotherapy, pain management, and certain blood products;
- (C) Related nursing care and supplies.

- (20) **Maternity Care.** The Plan covers charges in connection with prenatal care, delivery and postpartum care, including inpatient routine nursing care. Maternity care includes, but is not limited to, pre and post natal office visits, associated diagnostic tests, laboratory tests and x-ray charges, semi-private room, general nursing care, Provider services, anesthesia if Medically Necessary, and ancillary services. The Plan also covers parent education, assistance and training in breast and bottle feeding and the performance of any necessary maternal clinical assessments.

The Plan covers Maternity Care for a Dependent Child. The Plan covers complications of a pregnancy for a Dependent Child. The Plan covers an elective abortion (chemically or surgically induced).

The provisions of the Newborns' and Mothers' Health Protection Act of 1996 provide for a minimum length of stay for the birth of a newborn. Benefits payable under this Plan for a maternity-related Hospital stay must not be restricted for the mother or the newborn to less than 48 hours following a normal delivery or less than 96 hours following a cesarean section unless a shorter stay is agreed to by both the mother and her attending physician.

All inpatient Hospital confinements in connection with childbirth in excess of 48 hours following a normal delivery or 96 hours following a cesarean section must be Post-Notified as described in the section entitled "Utilization Management and Medical Review". Failure to Post-Notify such additional confinement in a Hospital may result in a penalty.

Maternity Care Limitations and Exclusions: Home deliveries are not covered.

- (21) **Mental Illness Treatment.** The Plan covers inpatient confinement for Mental Illness in a Hospital, Behavioral Health Care Facility, or Residential Treatment Facility.

Partial Hospitalization is covered when Medically Necessary. Two partial days in an approved Behavioral Health Care Facility or Residential Treatment Facility equal one inpatient day.

The Plan also covers outpatient treatment, including Emergency visits. Outpatient treatment may be furnished in an outpatient department of a Hospital, including the Emergency room, in a Behavioral Health Care Facility, or in a physician's office.

The Plan covers Medically Necessary electro-shock therapy when provided at a Hospital. Associated expenses for a Hospital operating room and for the anesthesiologist are covered.

The Medical Services Team must be Pre-Notified of all inpatient admissions for the treatment of Mental Illness and outpatient Mental Illness services must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Notify or Pre-Certify may result in a penalty.

Mental Illness Treatment Limitations and Exclusions: Treatment must be directly related to a Mental Illness (as defined). Benefits are not payable for care primarily directed at raising the level of consciousness, social enhancement, retraining, professional training, educational therapy, mental retardation, developmental delays, cognitive training, or counseling limited to everyday problems of living, marriage counseling, family counseling, sex therapy, or support groups. Under no circumstances will benefits be provided for therapy that includes the satisfaction of requirements for professional training.

- (22) **Newborn Care.** The Plan covers newborn care including nursery charges, charges for routine Provider examinations and tests and charges for routine procedures such as circumcision.

Pre-Notification is recommended, but not required when the newborn will be a Covered Family Member but the mother will not be Covered. Post-Notification is required when any newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.

- (23) **Nutritional Counseling.** The Plan covers Medically Necessary nutritional counseling by a certified dietician/nutritionist when prescribed by a physician.

- (24) **Nutritional Supplements.** The Prescription Drug Expense Benefit covers the cost of enteral nutrition formulas that are given by mouth or enterally (through a feeding tube) for home use prescribed by a Provider as a Medically Necessary, effective treatment of a condition that would cause malnourishment, chronic disability, mental retardation, or death. Treatment must be rendered according to a written treatment plan and must be approved prior to the services being rendered.

Enteral formulas have been proven to be effective in the treatment of Crohn's disease, multiple severe food allergies, inherited diseases of the amino acid and organic acid metabolism, gastroesophageal reflux with failure to thrive, disorders of gastrointestinal motility such as chronic pseudo-obstruction and other diseases not listed.

Nutritional Supplements Limitations and Exclusions: Nutritional supplements that are taken electively are not covered. Modified solid food products are not covered.

- (25) **Obesity Treatment.** The plan covers treatment of obesity as defined by the National Heart Lung Blood Institute if a Covered Family Member has a body mass index (BMI) of greater than 30. Treatment must be rendered according to a written treatment plan on an outpatient basis. A course of treatment begins and ends as specified in the treatment plan or sooner if the Covered Family Member discontinues treatment. The treatment plan must be approved prior to the services being rendered.

Obesity Treatment Limitations and Exclusions: The Plan does not cover surgical procedures intended for weight loss, including, but not limited to, gastric stapling, gastric bypass, and gastric bubble. The Plan covers one course of treatment, per Lifetime per Covered Family Member. Anything not included or not approved in the written treatment plan is not covered. Prescription appetite or weight control drugs

are not covered as a medical plan benefit even when included as part of a written treatment plan; however, such prescription drugs may be covered under the Prescription Drug Expense Benefit with prior authorization. Non-prescription appetite or weight control drugs, dietary supplements, special foods or food supplements, health or weight control centers or resorts and health club memberships, subscriptions to books and exercise equipment also are not covered.

- (26) **Occupational Therapy.** The Plan covers occupational therapy rendered by a licensed occupational therapist. The therapy must be Medically Necessary as outlined in a plan of treatment by the attending physician and expected to restore bodily functions within a reasonable period of time.

Occupational Therapy Limitations and Exclusions: Therapy designed to prevent further deterioration is not covered.

- (27) **Organ Transplants.** The Plan covers Medically Necessary organ and tissue transplants that are not considered Experimental or Investigative.

The Plan also covers live donor expenses. The Plan will cover the expenses of the donor who is not a Covered Family Member under this Plan provided there is no other coverage available. If other coverage is available to the donor, this Plan will be the secondary payer.

The following conditions must apply to such procedures:

- (A) The procedure must be performed at a facility known for having an effective program for doing such procedures, and
- (B) The Covered Family Member must be a likely candidate for the successful outcome of such a procedure, and
- (C) Medical expenses for the donor and the recipient must be considered Allowable Expenses under this Plan.

Benefits are payable for the following:

- (A) The cost of registering the Covered Family Member recipient with a transplant registry.
- (B) Pre-transplant services provided to donors in anticipation of a transplant. Covered Services include laboratory tests (including tissue typing), and general medical evaluations.
- (C) Acquisition services for an organ from a living donor or from a cadaver. Organ transplant expenses to include transportation of the organ to the place of transplantation, including the cost of a technician, packing and preservation, and injections of antibodies, but not charges for lodging or meals of a courier, or finder's fees.
- (D) Charges for transportation of the recipient from one facility to another facility where the procedure will be performed.
- (E) Routine post-operative care for both the recipient and donor as well as for complications that result from the procedure.

All transplant procedures must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.

Travel Benefit: The Plan covers reasonable and necessary travel, meal and lodging costs incurred during the treatment plan.

The Plan does not cover:

- (A) Travel expenses, lodging, and meals when the program provider is less than 50 miles from the Covered Family Member's home, or
- (B) Personal expenses incurred to maintain the Covered Family Member's residence while traveling to and from the program provider and during the length of stay. Examples of such expenses include, but are not limited to childcare costs, house sitting costs, and kennel charges, or
- (C) Charges for the repair or maintenance of a motor vehicle, or
- (D) Reimbursement of any wages lost by the Covered Family Member during the treatment plan.

Organ Transplants Limitations and Exclusions: The Plan does not cover:

- (A) Legal fees, finder fees, and any other fee paid to or on behalf of the donor for the organ or tissue.
- (B) Charges incurred for mechanical devices designed to replace human organs (except for charges for a kidney dialysis machine or use of a mechanical heart to keep a patient alive until a human heart donor becomes available).
- (C) Charges incurred for keeping a donor alive for transplant purposes.

- (28) **Physical Rehabilitation Facility.** The Plan covers charges by a Rehabilitation Facility. The Plan covers inpatient charges if the confinement starts within 30 days of a Hospital stay or 30 days of another Rehabilitation Facility or Convalescent/Skilled Nursing Facility confinement. The previous inpatient Hospital confinement must have been for a minimum of three consecutive days for which inpatient Hospital expense benefits are payable by the Plan. A plan of treatment must be established by the attending physician at the time rehabilitation service is provided and must demonstrate the Medical Necessity of the treatment, including the need for continuous care of a physician and 24-hour-a-day nursing skilled care. The physician must be qualified in the state of jurisdiction to prescribe the plan of treatment recommended, must remain available to visit the patient during the admission and provide the patient continuous care. The physician may not have any financial interest in the Rehabilitation Facility.

The Plan covers the daily charge for room and board that does not exceed the semi-private rate, or if the facility does not have a semi-private room available. The Plan will pay the lowest daily rate for the private room and board charge. Outpatient care for physical, occupational, and speech therapy and other services shown in the Schedule of Benefits is covered.

All inpatient admissions to a Physical Rehabilitation Facility must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.

- (29) **Physical Therapy.** The Plan covers physical therapy rendered by a licensed physical therapist. The therapy must be Medically Necessary as outlined in a plan of treatment by the attending physician and expected to restore bodily function within a reasonable period of time.

Physical Therapy Limitations and Exclusions: Therapy designed to prevent further deterioration is not covered.

- (30) **Physician and Health Care Providers.** The Plan covers:

- (A) **Office and Inpatient Visits.** The Plan covers non-surgical office and inpatient visit charges by a physician or other Provider for treatment of an Injury or Sickness. Inpatient or outpatient Provider visits and office consultations by a specialist are also covered.
- (B) **Surgery.** The Plan covers Medically Necessary surgery, co-surgery, assistant surgery, and Reconstructive Surgery.

Surgery (including multiple surgery or multiple surgical procedures) is defined by the American Medical Association's Current Procedural Terminology (CPT) and by the Healthcare Common Procedure Coding System (HCPCS). All surgical procedures, including multiple surgical procedures, are subject to clinical edits and must fall within standards of practice as defined by the American Medical Association, are subject to review for Medical Necessity, and approval by the appropriate governmental agency. Surgery will include physical complications in all stages of covered surgeries including, but not limited to, mastectomies and lymphedema.

If more than one surgical procedure is performed at the same time, the Plan's reimbursement will be based on the full Allowable Expense for the primary procedure. The Plan's reimbursement for additional procedures may be reduced to ½ of the Allowable Expense for the additional procedures.

If the services of an assistant surgeon are determined to be Medically Necessary, the Plan's reimbursement for the assistant surgeon's Covered Services will be limited to 20% of the Allowable Expense for the surgical procedure.

The Medical Services Team must be Pre-Notified of all surgical procedures (except for office surgeries) and certain elective surgical procedures must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Notify or Pre-Certify may result in a penalty.

- (C) **Second Surgical Opinion.** The Plan covers charges for a second surgical opinion including associated x-rays and tests. This Plan also covers charges for a third opinion, including associated x-rays and tests if necessary, if the second opinion differs from the first.

Second opinions, (and third opinions when necessary), must be rendered by physicians who are board certified, and qualified by reason of their specialty,

to give an opinion on the proposed surgery or Hospital admission. The physician must not be a business associate of the physician who recommended surgery or the Hospital admission.

- (D) **Second Medical Opinion.** The Plan covers charges for a second medical opinion by an appropriate specialist for either a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment for cancer.
- (E) **Treatment of Injury to a Tooth.** The Plan covers treatment of an Injury to sound, natural teeth. The Injury must not be caused, directly or indirectly, by biting or chewing. Treatment includes replacing natural teeth lost due to such Injury. A sound natural tooth is any tooth that has adequate bone structure, healthy periodontium, and healthy support tissue. A tooth may have been restored in any manner including fillings or a crown but will still be considered a sound and natural tooth as long as the “support” of the tooth remains intact. The above dental services will be covered if they can be identified in the Current Dental Terminology (CDT) developed by the American Dental Association.
- (31) **Podiatrist.** The Plan covers charges by a podiatrist for treatment of an Injury, Sickness, or deformity of the feet.
- (32) **Preadmission Testing.** The Plan covers preadmission testing prior to surgery. Tests must be performed in association with a planned admission and must be accepted by the Hospital in place of the same post-admission tests. Tests repeated after admission or before surgery are not covered, unless the admission or surgery is deferred solely due to a change in the health of the Covered Family Member.
- (33) **Prescription Drug Administration.** The Medical Expense Benefit portion of the Plan will also cover the associated administration or insertion of the covered prescription or device.
- (34) **Preventative Care and Well Care.** The Plan covers:
 - (A) **Preventative Care for a Child.** The Plan covers routine preventative/well-care visits up to age 19 for a Dependent Child.

This benefit includes an initial Hospital check-up and well-child visits as recommended by the attending physician. Covered Services include the following: medical histories, complete physical exams, developmental assessments, anticipatory guidance, appropriate immunizations as recommended by the American Academy of Pediatrics, x-ray, lab tests and other routine tests ordered at the time of the visit which are done in the physician’s office, in a clinical laboratory or x-ray facility.
 - (B) **Preventative Care for an Adult.** The Plan covers routine preventative care for an adult Covered Family Member as recommended by the attending physician as described on the Schedule of Benefits. Such care includes medical testing, routine physical exams including related laboratory tests, x-rays, appropriate routine immunizations and vaccines when provided by your PCP.

- (C) **Routine Pap Smears and Pelvic Exams.** The Plan covers charges for routine pap smears and pelvic exams as recommended by the attending physician and that are accepted medical practice.

A PCP referral is not required for these services.

- (D) **Routine Mammography Screening.** The Plan covers charges for routine mammography screenings. Routine mammograms are covered subject to the following limits:

- (i) Upon the recommendation of the attending physician, at any age if a Covered Family Member has a prior history of breast cancer or whose mother, sister or daughter has a prior history of breast cancer;
- (ii) A single baseline mammogram for Covered Family Members age 35 to 39 years of age;
- (iii) Once every two years for Covered Family Members age 40 to 49; or
- (iv) An annual mammogram for Covered Family Members age 50 and older.

- (E) **Prostate Cancer Screening.** The Plan covers prostate cancer screenings subject to the following limits:

- (i) Standard diagnostic testing, including a digital rectal examination and a prostate specific antigen test, at any age for men having a prior history of prostate cancer; and
- (ii) An annual standard diagnostic examination, including a digital rectal examination and a prostate specific antigen test for men age 50 and over who are not symptomatic and for men age 40 with a family history of prostate cancer or other prostate cancer risk factors.

- (F) **Colon Cancer Screening.** The Plan covers a routine screenings for colon cancer including, but not limited to colonoscopies, for Covered Family Members as recommended by the attending physician.

All surgical procedures must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.

- (G) **Family Planning.** The Plan covers Allowable Expenses related to family planning including: voluntary sterilization of males and females. Elective abortions are also covered. The reversal of a voluntary sterilization is not covered.

- (H) **Routine Vision Care.** The Plan covers benefits for routine vision exams up to the limit described in the Schedule of Benefits. A vision exam means an eye care exam for prescribing, fitting or determining the need for eyeglasses or contact lenses. Frames and lenses are not covered.

A PCP referral is not required for these services.

- (l) **Bone Density Testing.** The Plan covers bone mineral density measurements and tests for the detection of osteoporosis if medically appropriate and recommended by the attending physician.
- (35) **Respiratory Therapy.** The Plan covers respiratory therapy rendered by a licensed respiratory therapist.
- (36) **Speech Therapy.** The Plan covers speech therapy rendered by a licensed speech therapist when needed by a Covered Family Member due to Injury or Sickness. Speech therapy must be performed to restore speech that was lost due to an Injury or Sickness. The treatment must also be active treatment for a medical condition resulting in functional defect or be for the correction of a speech impairment resulting from said Injury or Sickness, including previous therapeutic processes.

All speech therapy must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.

Speech Therapy Limitations and Exclusions: This Plan does not cover speech therapy services that are educational in any part, or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders.

- (37) **Substance Abuse Treatment.** The Plan covers inpatient confinement for detoxification for the treatment of Substance Abuse in a Hospital or Behavioral Health Care Facility.

The Plan also covers outpatient treatment, including Emergency visits. Twenty of these visits may be used by other Covered Family Members even if the Covered Family Member in need of Substance Abuse treatment is not receiving it. Benefits for family visits are limited to one per day.

The Medical Services Team must be Pre-Notified of all inpatient admissions for the treatment of Substance Abuse and outpatient Substance Abuse services must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Notify or Pre-Certify may result in a penalty.

Substance Abuse Treatment Limitations and Exclusions: The Plan does not cover inpatient rehabilitation for the treatment of Substance Abuse.

- (38) **Urgent Care Facility.** The Plan will pay for Covered Services rendered in an Urgent Care Facility.

MEDICAL EXPENSE BENEFITS SPECIAL CONDITIONS

This Plan requires referrals or Prior Authorization from the PCP for additional services including the care of a specialist. The PCP may obtain a referral or Prior Authorization by calling the toll-free number on the back of the Covered Family Member's benefit identification card. When obtaining a referral or Prior Authorization for a hospital admission, surgery or other treatment that includes ancillary services such as anesthesia, radiology and pathology, the PCP is only required to Pre-Authorize the admission or the main procedure, not the ancillary services. The following services do not require a PCP referral:

- (1) Emergency services; however, the Covered Family Member must get a referral from their PCP for follow-up care.
- (2) Obstetric and gynecological services.
- (3) Routine eye exams.

The Claim Administrator will pay benefits directly to the Provider for Covered Services less any applicable Coinsurance, deductible, or Copayment. If you or your Covered Dependent seeks care or treatment from a provider who is not a member of the Preferred Provider Network, medical expense benefits will be denied. If a non-participating provider must be utilized, the Covered Family Member or referring provider is responsible for notifying RMSCO Medical Management at least 10 days prior to the service. Otherwise, benefits will be denied.

Due to changes that may occur in the participation status of the Provider, it is the responsibility of the Employee to verify that the Provider is still a Participating member. A list of Preferred Providers is available from your Employer, or via the Internet at www.rmscoinc.com.

Alternate Treatment: The Plan may cover an alternate procedure, service or course of Medically Necessary treatment if the alternate treatment can be performed to properly treat an Injury or Sickness. Included in this benefit are dental procedures that are being performed when an underlying medical condition could deteriorate if the Dental procedure is not done. The Plan will provide coverage if the alternate procedure is more cost effective or medically sound, even if the alternative procedure is not specified in the section entitled "Detailed Description of Benefits".

Limitations and Exclusions: No benefits are payable under the Medical Expense section for any expenses incurred:

- (1) For, or in connection, with treatment of the teeth or periodontium, unless such expenses are listed elsewhere in the Plan as a Covered Service.
- (2) For any Copayment payable under the terms of the section entitled "Prescription Drug Expense Benefit".
- (3) Which result from circumstances outlined under the section entitled "Plan Exclusions".

PRESCRIPTION DRUG EXPENSE BENEFIT

(**NOTE:** The prescription drug benefits listed below are subject to change at any time. Please contact the Pharmacy Benefit Manager using the phone number on the back of your Employee Benefit Card for the most current coverage information.)

Covered Family Members may obtain a Brand Name Drug or a Generic Drug by presenting their benefit identification card at a retail pharmacy or through the mail order pharmacy program.

Non-Participating Retail Pharmacy: When you purchase a prescription at a non-participating retail pharmacy, you must pay the full cost of the prescription and submit the claim to the Pharmacy Benefit Manager for coverage under the Plan. You may submit the claim by obtaining a claim form from the Pharmacy Benefit Manager or the Plan Administrator.

Participating Retail Pharmacy: When you go to a pharmacy that is a member of the Pharmacy Benefit Manager's network, you must give the pharmacist your benefit identification card. You will be required to pay the required Copay and the pharmacy will file the claim with the Pharmacy Benefit Manager. A Participating Retail Pharmacy may be located by contacting the Pharmacy Benefit Manager at the telephone number on your benefit identification card.

Mail Order Pharmacy Benefit: Covered Family Members may obtain prescription medications by mail order through the Plan's mail order pharmacy benefit. The Plan will cover the entire cost of the drug less the Copayment amount indicated in the Schedule of Benefits. No deductible will apply.

If a physician advises a Covered Family Member that a maintenance medication is required, the Family Member should obtain two prescriptions from the physician. The first prescription should be for a period not to exceed 30 consecutive days, and should be filled using the retail pharmacy procedure previously described. The second prescription should be written for up to a 90-day supply, with up to three refills and should be mailed directly to the Pharmacy Benefit Manager with an order form that can be obtained from the Plan Administrator. Refills can be obtained by calling the Pharmacy Benefit Manager at the toll-free number listed on the order form. Subsequent refills will be mailed directly to the Covered Family Member.

The Pharmacy Benefit Manager will refill a prescription up to the lesser of one year or the number of refills written on the prescription. After this period of time, a new prescription will be required from the physician.

When two or more prescriptions or refills are dispensed at the same time, a Copayment must be paid for each prescription order or refill. When a treatment regimen contains more than one type of drug and the drugs are packaged together for the convenience of the Covered Family Member, a Copayment will apply to each type of drug.

Prior Authorization: Some prescription medications require Prior Authorization before they can be dispensed either at a retail pharmacy or through the mail order program. If your prescription requires Prior Authorization, you must contact the Pharmacy Benefit Manager at the toll-free phone number on your benefit identification card for instructions. If the Pharmacy Benefit Manager approves coverage for the prescription, you will be permitted to fill the prescription. If authorization is not given, you may appeal the decision to the Pharmacy Benefit Manager. If you purchase a prescription that requires Prior Authorization without first obtaining that authorization, the prescription will not be covered under the Plan.

Covered Drugs: The Prescription Drug Plan pays for the following legend drugs:

- (1) Federal legend drugs – Any product that bears the legend, “Caution: Federal Law prohibits dispensing without a prescription”.
- (2) State restricted drugs.
- (3) Compounded medication of which at least one ingredient is a legend drug.
- (4) Insulin.
- (5) Insulin needles and syringes.
- (6) Over-the-counter diabetic supplies (all dosage forms except Glucowatch Products).
- (7) Insulin administration supplies.
- (8) Retin-A through age 19.
- (9) Oral, transdermal, or intravaginal contraceptives.
- (10) 91-day prepackaged oral contraceptives.
- (11) Legend pediatric fluoride vitamin drops up to 50-day supply.
- (12) Anti-obesity preparations (with prior authorization).

Prescription Drug Limitations and Exclusions: In addition to the Plan Exclusions and other provisions of the Plan, benefits are not included for the following:

- (1) Drugs or medicines that are legally available without a doctor’s prescription (over-the-counter or non-legend drugs, except insulin).
- (2) Contraceptive jellies, creams, foams, devices, implants or injections.
- (3) Growth hormones.
- (4) Glucowatch products.
- (5) Retin-A age 20 and over.
- (6) Mifeprex.
- (7) Therapeutic devices or appliances.
- (8) Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.
- (9) Allergy sera.
- (10) Immunization agents and vaccines.
- (11) Blood or blood plasma products.
- (12) Experimental drugs or drugs labeled with the statement: “Caution – Limited by Federal Law to Investigational Use” or similar wording.
- (13) Medication for which the cost is recoverable under any Workers’ Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the Covered Family Member.
- (14) Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, Skilled Nursing Facility, Convalescent Care Facility, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- (15) Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician’s original order.
- (16) Charges for the administration of any drug.

DENTAL EXPENSE BENEFIT

The Plan will provide benefits for the following dental services as described in the Schedule of Benefits. The Plan will only provide preventive dental services for Covered Family Members under 19 years of age.

Preventive Dental Services (Type I): The Plan covers the following Type I dental services when such services are rendered by a licensed dentist:

- (1) Palliative Emergency Treatment. Includes treatment for the purpose of removing or alleviating pain and sedative fillings. Any x-ray taken in connection with such services is a separate dental service.
- (2) Routine Oral Examinations. The Plan covers the Allowable Expense for routine examinations limited to twice per Covered Family Member in any Calendar Year.
- (3) Prophylaxis. Includes the cleaning and scaling of teeth; limited to twice per Covered Family Member in any Calendar Year. Includes periodontal prophylaxis.
- (4) Fluoride Applications. Includes the topical application of fluoride solutions for Dependent Children under 18 years of age; limited to one application per Calendar Year.
- (5) Sealants. The Plan covers the costs of application of dental sealants on a permanent, non-restored posterior tooth for a Covered Family Member less than 18 years of age. Benefits are limited to one treatment per tooth in any consecutive 36-month period. Benefits are limited to application on occlusal surfaces only.
- (6) Space Maintainers. The Plan covers charges for space maintainers for Children between the ages of six and sixteen. The allowance includes charges for any adjustments which are made within six months of the installation of the space maintainers. Charges are limited to the insertion of the initial appliance only, and only when utilized for non-orthodontic treatments. Covered space maintainers will include fixed, unilateral, band or stainless steel crown type; or fixed, unilateral, cast type; or removable, bilateral type.
- (7) Fixed and Removable Appliances. Benefits are limited to Covered Dependents under age 16 and limited to the installation of the initial appliance only. Benefits are limited to appliances for control of harmful habits, such as thumb sucking. The allowance will include all adjustments made within the first six months of installation.
- (8) Diagnostic X-Rays. Benefits include full mouth series (limited to once during any consecutive 36-month period); Bitewing films (limited to a maximum of four films in any consecutive 12-month period); Panoramic films (limited to once in any consecutive 36-month period); maxilla and mandible films (limited to once in any consecutive 36-month period); and other x-rays as required for diagnostic purposes.

PLAN EXCLUSIONS

The following general exclusions apply to all sections of this Plan. Specific Limitations and Exclusions for individual Plan benefits are indicated in the Schedule of Benefits or with that benefit in the Detailed Description of Benefits.

- (1) **Acupuncture.** The Plan does not cover acupuncture except when used in lieu of general anesthesia.
- (2) **Alternative Service.** The Plan will not provide benefits for alternative or complementary health services, products, remedies, treatment and therapies including, but not limited to, hypnosis, and hypnotherapy, naturopathy, homeopathy, primal therapy, carbon dioxide therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, aroma therapy, hair analysis, thermograms and thermography, yoga, meditation, and recreational therapy and any related diagnostic testing.
- (3) **Athletic Equipment.** The Plan does not cover devices or equipment used primarily for the purpose of athletic activities.
- (4) **Any Other Employment.** The Plan does not cover treatment in connection with a Sickness, Injury, occupational disease or condition arising out of, or in the course of, any employment for wage, profit, intent of profit, or self-employment, or for which the Covered Family Member is or was entitled to receive workers' compensation benefits.

This also includes any Sickness or Injury arising out of the business pursuits of a Covered Family Member in connection with a business owned or financially controlled by the Covered Family Member or by a partnership, corporation or other working arrangement of which the Covered Family Member is a partner or member. A business pursuit is a continuous or regular activity engaged in by the Covered Family Member for the purpose of earning a profit, whether or not the business is profitable or a livelihood. The business pursuit exclusion is intended to apply to any activities that are involved with one's business, employment, trade, occupation, or profession.

This exclusion applies even if the Covered Family Member's right to workers' compensation has been waived, qualified, or not asserted.

- (5) **Automobile Insurance.** The Plan does not cover treatment for which the Covered Family Member is eligible to receive benefits through mandatory no fault, fault automobile, or tort insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. The Claim Administrator will take into consideration any adjustment option chosen under such part by the Covered Family Member. This exclusion applies even if the Covered Family Member fails to make a proper or timely claim for benefits available to them under any available no-fault or similar policy or if they fail to appear at any hearing. The Plan will also not provide benefits even if the Covered Family Member brings a lawsuit against the person who caused the Sickness or Injury and even if the Covered Family Member received money from that lawsuit and have repaid the medical expenses they received payment for under the no-fault or similar policy.

- (6) **Aviation.** The Plan does not cover benefits for any Sickness or Injury directly relating from air travel, except when the Covered Family Member is a passenger on a commercial airline scheduled flight.
- (7) **Biofeedback.** The Plan does not cover biofeedback except when used for the treatment of urinary incontinence.
- (8) **Blood Products.** The Plan does not cover charges for whole blood, blood plasma, packed blood cells, or other blood products or derivatives if a volunteer blood replacement program is available. The Plan will not cover the storage and destruction of blood.
- (9) **Civil and Criminal Misconduct.** The Plan does not cover treatment for, or in connection with, any Sickness or Injury that arises while committing or attempting to commit a felony or participating in a riot or insurrection. The felony, riot or insurrection will be determined by the law of the State where the criminal behavior occurred.
- (10) **Clothing.** The Plan does not cover charges for special clothing, except for Medically Necessary burn garments or lymphedema garments.
- (11) **Communication Devices.** The Plan will not provided benefits for the purchase, rental, repair, replacement or maintenance of devices for speaking, listening, or otherwise communicating, including, but not limited to telecommunication devices for the deaf (TDDs) and teletype machines (TTYs) , or for services for evaluation, fitting , or modification of such devices.
- (12) **Contraceptives.** The medical portion of the Plan does not cover contraceptive devices including intrauterine devices and injectable contraceptives such as Norplant. However, the medical portion of the Plan does cover the physician's charges for the insertion or administration of a contraceptive that is covered under the section entitled "Prescription Drug Expense Benefit".
- (13) **Cosmetic Procedures.** The Plan does not cover cosmetic surgery or procedures, unless it qualifies as Reconstructive Surgery as defined, including human or artificial hair transplants or any drug, prescription or otherwise, used to eliminate baldness.
- (14) **Court Mandated Services.** The Plan does not cover charges related to court mandated non-Medically Necessary services for therapy or treatment for Mental Illness, Substance Abuse or any other health services. The Plan will retain the right to cover such services if they are deemed to be Medically Necessary.
- (15) **Custodial Care.** The Plan does not cover charges in connection with Custodial Care (except as specifically covered in the Plan) sanitariums, rest care, or nursing homes.
- (16) **Dental Implants.**
- (17) **Disallowed Benefits or Penalties.** The Plan does not cover charges for penalties or disallowed benefits determined by a primary health plan as determined in the section entitled "Coordination Of Benefits", Medicare, an HMO or other managed care plan due to failure of the covered person to obtain the proper Pre-Certification, second opinion,

or any other reason including failure to comply with the requirements of the primary care physician network established by the HMO or managed care plan or by voluntarily obtaining services outside the established provider network thereby incurring a reduction or denial of benefits. For any penalty imposed due to failure to adhere to the conditions of the section entitled "Utilization Management and Medical Review".

- (18) **Educational and Recreational Therapy.** The Plan does not cover charges for recreational or educational therapy, forms of self care or self help training, or marital, family or other counseling or training services unless specifically covered elsewhere under the Plan.
- (19) **Excessive Charges.** The Plan does not cover charges made which are in excess of Reasonable and Customary charges or the Preferred Provider's Reimbursement Schedule.
- (20) **Excluded Treatments.** The Plan does not cover charges incurred for treatment of Sickness or Injury that results directly or indirectly from a treatment, procedure or therapy which is excluded from coverage under this Plan. This exclusion does not apply to charges incurred for maternity or newborn care arising from a non-covered service.
- (21) **Experimental or Investigative.** The Plan does not cover any and all charges resulting from Experimental or Investigative procedures as defined in the Plan, including, but not limited to, all Experimental organ transplants and Experimental organ implants. For Experimental or Investigative drugs or substances not approved by the Food and Drug Administration or for drugs labeled "Caution - limited by Federal Law to investigational use," including any drug or substance which is Experimental or Investigative.
- (22) **Family Planning.** The Plan does not cover expenses related to a reversal of a sterilization operation, in vitro fertilization, and for a surrogate mother. However, the expenses for the birth of a Child as the result of in vitro fertilization or other methods of conception, will be covered and the expenses of the Child of a surrogate mother if the Child has been placed for adoption with the Covered Employee. "Placed" means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child.
- (23) **Foot Care.** The Plan does not cover routine or palliative foot care such as treatment of corns, calluses, toenails, flat feet, fallen arches, chronic foot strain, reduction of nails, or symptomatic complaints of the feet, except if necessitated due to metabolic conditions such as diabetes.
- (24) **Foot Orthotics.**
- (25) **Foreign Medical Care.** The Plan does not cover foreign medical care except for Emergency services, the Plan does not cover charges incurred by a Covered Family Member for drugs, procedures, services, supplies or treatment accessed outside the United States, its possessions or the countries of Canada or Mexico.

- (26) **Government Hospitals.** The Plan does not cover services or supplies furnished to the Covered Family Member in a Hospital owned or operated by the United States Government or any other government or in a facility maintained by the Veteran's Administration unless there is a legal obligation to pay such charges without regard to the existence of any coverage.
- (27) **Hearing Aids and Examinations.** The Plan does not cover hearing aids, audiological hearing examinations by an audiologist or other physician, or the prescription or fitting of hearing aids, except as specifically provided for in this Plan.
- (28) **Herbal and Homeopathic Remedies.**
- (29) **Ineligibility.** The Plan does not cover charges that are incurred before a participant becomes Covered by the Plan, after the Covered Family Member's coverage ended, or after the Plan has terminated.
- (30) **Interns and Residents.** The Plan does not cover services rendered and billed by a resident physician or intern while serving in that capacity.
- (31) **Late Filed Claims.** The Plan does not cover bills submitted to the Plan after the timely filing limitation as described in section entitled "Timely Claim Filing Requirement".
- (32) **Licensing and Certification Restrictions.** The Plan does not cover charges for care, services, or supplies rendered which are not within the scope of the professional license of the person providing them.
- (33) **Massage Therapy.** The Plan does not cover massage therapy unless it is performed by a licensed Provider, such as a physical therapist or a chiropractor, and is an integral part of a therapy treatment plan that has been approved by the Plan.
- (34) **Medical Equipment and Supplies.** The Plan does not cover any charge for equipment that does not meet the definition of Durable Medical Equipment, including but not limited to: air conditioners, humidifiers, exercise equipment, etc.
- (35) **Medicare.** The Plan does not cover charges to the extent that the Covered Family Member is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by Medicare. (This exclusion will not apply if this Plan is obligated by law to pay its benefits before Medicare.) Any individual who, at any time, was entitled to enroll in all or any portion of the Medicare program but who did not so enroll, will be considered to be entitled to reimbursement in an amount equal to the amount to which he would have been entitled, if any, if he were so enrolled.
- (36) **Methadone and Buprenorphine Maintenance.** The Plan does not cover methadone maintenance and buprenorphine maintenance, including any prescription or non-prescription drugs.
- (37) **Military Service-Connected Sickesses or Injuries.** The Plan does not cover any services in connection with any military service-connected Sickness or Injury if the Veteran's Administration is responsible for providing such services.

- (38) **Non-Emergency Services.** The Plan does not provide benefits for Emergency services rendered for a non-Emergency medical condition (as defined by the Plan).
- (39) **Non-Recognized Provider.** The Plan does not cover any services or supplies provided by an individual who does not meet the Plan definition of Provider or Health Care Provider.
- (40) **Not Legally Required to Pay.** The Plan does not cover charges which would not have been made if no coverage had existed or for which the Covered Family Member is not legally required to pay, or payment is unlawful in the jurisdiction where the person resides at the time expenses are incurred.
- (41) **Not Medically Necessary.** The Plan does not cover charges that are not Medically Necessary, as defined, except as specifically provided for in this Plan.

The fact that a physician may prescribe, order, recommend or approve a procedure, treatment, facility, supply, device, or drug does not, in and of itself, make it "Medically Necessary" or make the charge a Covered Service under the Plan, even if it has not been listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.

- (42) **Non-Standard Allergy Services.** The Plan does not cover non-standard allergy services, including, but not limited to, skin titration, cytotoxicity testing, and treatment of non-specific candida sensitivity and urine autoinjections.
- (43) **Obesity Treatment/Weight Reduction.** The Plan does not cover charges for treatment of obesity, weight reduction, diet programs (Weight Watchers, Nutrisystem, etc.) or diet supplements. The Plan will not pay for any surgical procedures intended for weight loss. Obesity treatment that does not meet the criteria described under "Obesity Treatment" in the subsection entitled "Medical Expense Benefits" is not covered.
- (44) **Orthopedic Shoes.**
- (45) **Other Party Liability.** The Plan does not cover charges with respect to any Sickness or Injury for which any party other than the Plan may be legally responsible or liable unless the Covered Family Member fully complies with the section entitled "Subrogation/Reimbursement Provision".
- (46) **Out-of-Area Dependent Student.** The Plan does not cover services accessed by an out-of-area Dependent Student unless such services are accessed in the manner specified in the subsection entitled "Dependent Student Coverage", in the section entitled "Detailed Description of Benefits".
- (47) **Outside HMO Program.** The Plan does not cover services for which the Covered Family Member does not follow the provisions described in the subsection entitled "Health Maintenance Organization Program".
- (48) **Over-the-Counter Medical Drugs and Medical Supplies.** The Plan does not cover any items that can be obtained without a prescription, except for diabetic supplies and as otherwise allowed in the Plan.

- (49) **Patient Charges and Penalties.** The Plan does not cover telephone consultations, charges for failure to keep a scheduled visit, or charges for the completion of claim forms, new patient processing, and late payment, penalty or interest charges caused by the patient's action or inaction.
- (50) **Physical Exams.** The Plan does not cover routine exams and immunizations for the sole purpose of school, insurance, marriage, licensing, camp, sports, adoption, medical research, custody, divorce, employment, travel to a foreign country or extracurricular activities.
- (51) **Private Duty Nursing.**
- (52) **Public or Government Program Reimbursements.** The Plan does not cover charges to the extent that the Covered Family Member is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any public or government program or applicable law, other than the program of Medical Assistance for Needy Persons (Medicaid).
- (53) **Room and Board.** The Plan does not cover charges incurred for room and board for a Covered Family Member in any Hospital or facility for any period of time during which that individual was not physically present.
- (54) **Refractive Eye Surgery.** The Plan does not cover eye surgery for the correction of visual acuity, including, but not limited to, LASIK and radial keratotomy.
- (55) **Routine Physical Examinations/Services.** The Plan does not cover routine exams and services rendered in a Hospital during an inpatient confinement (except charges for routine nursery care of newborn Child), unless otherwise specified in the Plan.
- (56) **Services of a Relative or Household Member.** The Plan does not cover services provided by your immediate family (the patient's Spouse, children, brother, sisters, parent of Spouse or other person residing with the patient).
- (57) **Sex Reassignment Surgery and Related Services.** The Plan does not cover hormone therapy, sexual reassignment surgery, counseling for transsexuals, and related charges to alter the physical characteristics of your biologically determined gender to those of another gender.
- (58) **Smoking and Caffeine Cessation Programs.** The Plan does not cover tobacco smoking or caffeine cessation programs. Prescription drugs to help stop smoking are not covered as a medical plan benefit even when included as part of a written treatment plan. Non-prescription drugs that help to stop smoking are also not covered.
- (59) **Temporomandibular Joint Dysfunction (TMJ).** The Plan does not cover charges for treatment of temporomandibular joint dysfunction (TMJ).
- (60) **Training.** The Plan does not cover expenses incurred for education or training (except as specifically covered in the Plan) including training for dyslexia and similar procedures, perceptual training and learning disability training.

- (61) **Travel or Transportation.** The Plan does not cover charges incurred for travel, other than transportation via Medically Necessary ambulance, or as otherwise specified in the Plan.
- (62) **Vision Therapy.** The Plan does not cover vision therapy or training for dyslexia and similar procedures, perceptual training and learning disability training. However the Plan covers vision therapy when Medically Necessary for certain conditions including, but not limited to, amblyopia, esotropia, and convergence insufficiency.
- (63) **War.** The Plan does not cover benefits for any Injuries or Sickness resulting from an act of terrorism or act of war (declared or undeclared).

CLAIM SUBMISSION

Either the Provider or the Covered Family Member must submit a claim form before reimbursement for an eligible expense can be paid. Claim forms are available from the Employer.

When submitting a claim form, include:

- (1) The Employer's name, and
- (2) The Employee's name, and
- (3) The Employee's Social Security Number, and
- (4) The full name of the Covered Family Member receiving treatment, and
- (5) An itemized bill reflecting a diagnosis, and
- (6) When the claim is the result of an accident, note the time and date of the accident and include a one or two sentence description of the circumstances.
- (7) When a Covered Family Member is covered under more than one health plan, and medical coverage under the Other Plan is primary, submit the claim to the Other Plan first. Then, submit a copy of the "explanation of benefits" from the Other Plan when submitting the claim to the Claim Administrator.

Payments will be made directly to Preferred Providers. All other payments will be made to the Employee unless there is an assignment of benefits on the claim. Submit claim forms to the Claim Administrator at:

RMSCO, Inc.
Attn: Group Claims
P.O. Box 6309
Syracuse, New York 13217-6309

KEEPING THE CLAIM FILE CURRENT

To avoid delays in processing claims notify the Employer at once:

- (1) Of an additional Eligible Dependent, or
- (2) If a Dependent(s) is no longer Eligible, or
- (3) If there is a change of address, or
- (4) If other coverage is elected or lost, or
- (5) If a Dependent Student is registered (every semester) for full-time attendance, or
- (6) If a Dependent Student or Child becomes incapable of self-sustaining employment.

TIMELY CLAIM FILING REQUIREMENT

All claims **must** be submitted within 180 days after the claim is incurred **or the claim will be denied**. If the Provider does not submit the claim it will be the Covered Family Member's responsibility to submit the claim. This includes, but is not limited to:

- (1) The initial claim submission, or
- (2) Follow up to a previously submitted claim. If a Benefit Determination is not received within 15 days, the Covered Family Member should verify that the Claim Administrator received the claim. Claims that are not filed within the timely filing requirement period will be denied.

The above time limit will be extended when additional information is needed in order to make a Benefit Determination. If a claim has been submitted within the time limit described above and the claim was pended due to insufficient information, the claim will be considered timely filed if the additional information is provided within 45 days **from the date the claim was originally pended**. Failure to furnish the additional information within the 45-day period **will result in the claim being denied** for lack of timely filing.

DETERMINATION OF BENEFITS

A Determination of Benefits will be made for every claim submitted to the Claim Administrator. The Determination of Benefits will be made within time limits established under the law. Claims submitted by a Provider, the Covered Family Member, or an Authorized Representative will be paid according to the procedures described in this section.

A benefit that is denied for lack of Medical Necessity, because it is a non-covered benefit, or because the Claim Administrator determines that the treatment is Experimental or Investigative will be considered an Adverse Determination.

The payment for any claim for a Covered Service is subject to clinical edits. The Plan will take into consideration appropriate health care practice under the standards of the case and by the

standards of a reasonably substantial, qualified, responsible, relevant segment of the health care community or government oversight agencies. All services or procedures, unless specifically stated otherwise, are subject to Medical Necessity review. The Claim Administrator will also have the right to make Benefit Determinations based on the Claim Administrator's Policies and Procedures Manual developed in conjunction with the above standards of practice, and health care professionals.

CLAIM DETERMINATION PROCEDURE

The Claim Administrator or the Medical Services Team will determine claims for benefits under this plan in one of the following ways:

- (1) **In-Network Claim Determination Procedure:** When a Covered Service is received from a member of this Plan's Preferred Provider Network, the claim will be submitted by the Provider and the Claim Administrator will pay the Provider directly. Network Providers agree to accept reimbursement using the Preferred Provider Reimbursement Schedule. The Covered Family Member may be required to make a Copayment, Coinsurance payment, or deductible payment at the time a service is received.
- (2) **Out-of-Network Claim Determination Procedure:** When a Covered Service is received from an out-of-network Provider, proof of the service must be submitted to the Claim Administrator using the out-of-network claim determination procedure described in the next subsection. When the Provider or the Covered Family Member submits a claim, the Claim Administrator will determine the amount of any reimbursement payable.
- (3) **Urgent Care Claims:** An expedited claim determination procedure will be followed whenever the Medical Services Team receives any communication from a Provider regarding an Urgent Care Claim. An Urgent Care Claim includes medical care or treatment that, when administered expeditiously would avoid serious jeopardy to the Covered Family Member's life, health, and ability to regain maximum function, or would avoid subjecting the Covered Family Member to severe pain that cannot be managed without the proposed care.

Any Provider may determine that a Covered Family Member requires Urgent Care. The Medical Services Team will make a claim determination for any Urgent Care Claim within the 72 hours following receipt of the Providers communication, unless the information submitted by the Provider is insufficient to make a Benefit Determination. Notification to the Provider may be made in any reasonable manner, including by telephone or in writing. Notification to the Covered Family Member will be made in writing as soon as possible, but no later than 72 hours after receiving a claim involving Urgent Care.

When a claim involving Urgent Care receives an Adverse Benefit Determination, an expedited appeal process is available. When an Urgent Care Claim is denied, in whole or in part, the Determination of Benefits for any appeal of the Adverse Benefit Determination will be made within the 72 hours following receipt of the appeal. No action at law or in equity will be brought to recover on the Plan until 72 hours following the filing of an appeal involving Urgent Care. No action will be brought at

all unless brought within 24 months of the Adverse Benefit Determination.

When there is insufficient information to make a Determination of Benefits for an Urgent Care Claim, the Claim Administrator will notify the Provider or Covered Family Member within 24 hours. The Claim Administrator's notice will state that the claim is incomplete, describe the information necessary to complete the claim, and indicate that the information must be provided within 48 hours. The Claim Administrator will then make a Determination of Benefits within the 48 hours after the earlier of (a) receiving the missing information or (b) the end of the additional period of time.

When Urgent Care or treatment is provided over an extended period of time, advance requests (requests submitted at least 24 hours in advance) for an extension of the initial time period will be determined within 24 hours. Requests for an extension that are received after the initial time period expired will be determined within 72 hours. Advance notice of any Plan amendment that would terminate or reduce the benefit will be provided.

If the proper procedures for filing an Urgent Care Claim are not followed, the Claim Administrator will notify the Covered Family Member and be given the proper procedures to follow as soon as possible, but no later than 24 hours following the failure.

- (4) Certification of a Pre-Service Claim: An expedited claim determination procedure will be followed whenever the Medical Services Team receives a request to certify the amount of benefit payable for a claim requiring Pre-Certification.

Whenever the Medical Services Team receives a claim requiring Pre-Certification, the amount of benefit will be determined within 15 days. Notification to the Provider may be made in any reasonable manner, including by telephone or in writing. Notification to the Covered Family Member will be made in writing as soon as possible, but no later than 15 days after receiving a claim requiring Pre-Certification. This time period may be extended up to an additional 15 days due to circumstances beyond the control of the Plan. In such a case, the Covered Family Member will be notified of the extension before the end of the initial 30-day period.

When insufficient information is submitted and a Determination of Benefits cannot be made, the Claim Administrator will notify the Covered Family Member and describe the missing information before the end of the initial 15-day claim determination period. If the Covered Family Member provides sufficient information within 45 days, the Determination of Benefits will be made within 15 days following receipt of the additional information.

If the proper procedures for filing a Pre-Service Claim are not followed, the Claim Administrator will notify the Covered Family Member and be given the proper procedures to follow as soon as possible, but no later than five days following the failure.

- (5) Certification of Concurrent Claims: An expedited claim determination procedure will be followed whenever the Medical Services Team receives a Concurrent Claim.

Whenever the Medical Services Team receives a request to certify a Concurrent Claim, including a request for an extension of the period of treatment, the amount of benefit will be determined within 24 hours of receiving the request. Notification to the Covered Family Member will be made in writing as soon as possible, but no later than 15 days after receiving the Concurrent Claim.

- (6) Post-Service Claims: A claim determination will be made and the Covered Family Member will be notified in writing as soon as possible, but no later than 30 days after the Claim Administrator received the claim. This time period may be extended up to an additional 15 days due to circumstances beyond the control of the Plan. In such a case, the Covered Family Member will be notified of the extension before the end of the initial 30-day period.

When insufficient information is submitted and a Determination of Benefits cannot be made, the Claim Administrator will notify the Covered Family Member and describe the missing information before the end of the initial 30-day claim determination period. If the Covered Family Member provides sufficient information within 45 days, the Determination of Benefits will be made within 15 days following receipt of the additional information.

ADVERSE DETERMINATION

The Covered Family Member will receive a written explanation of any Adverse Determination (a claim is wholly or partially denied) within 15 days after requesting Pre-Certification of a Pre-Service Claim described in the section entitled "Utilization Management And Medical Review" or within 30 days after filing a Post-Service Claim. The Covered Family Member or an Authorized Representative may file an appeal of an Adverse Determination involving Pre-Certification or a Post-Service Claim within 180 days of receiving written notification.

When Urgent Care is required, the Provider will be notified within 72 hours of any Adverse Determination. An expedited appeal process for an Adverse Determination involving Urgent Care is described in the subsection entitled "Claim Determination Procedure".

The Covered Family Member will be notified in the event that additional time or information is needed to review a claim. The notice will explain why benefits were denied, and will include the following information:

- (1) Specific reasons for the denial, and
- (2) Specific references to pertinent Plan provisions on which the denial is based, and
- (3) A description of any additional material or information necessary to complete the claim, and an explanation of why such material is necessary, and
- (4) An explanation of further appeals procedures, and
- (5) A statement that a failure to submit a written request for review within 180 days after the receipt of the denial will render the Adverse Determination final.
- (6) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Covered Family Member's right to bring a civil action under the law following an Adverse Determination on review, and
- (7) If an internal rule, guideline, protocol, or other similar criterion was relied upon in

- making the Adverse Determination, either such information; or a statement that such information was relied upon in making the Adverse Determination will be provided free of charge to the Covered Family Member upon request, and
- (8) If the Adverse Determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Covered Family Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request, and
 - (9) In the case of an Adverse Determination concerning a claim involving Urgent Care, a description of the expedited review process applicable to such claims.

CLAIM APPEALS

When an Adverse Determination of a non-Urgent Care claim is made (the claim was denied, in whole or in part) the Covered Family Member can take the following steps to appeal the Adverse Determination:

- (1) Write to the Claim Administrator within 180 calendar days of receiving the Adverse Determination (claims involving Urgent Care receive the expedited appeal process already described) and request an appeal. You may submit written comments, documents, records, and any other pertinent information relating to the claim. Copies of all information relevant to the claim for benefits will be available upon request. This information will be available without regard to whether or not the information was considered or relied upon in making the Adverse Determination. The review the Claim Administrator completes:
 - (A) Will take into account all submitted information, without regard to whether or not the information was submitted or considered in the initial Benefit Determination, and
 - (B) Will not provide deference to the initial determination, and
 - (C) Will not be decided by the individual who made the initial Adverse Determination or that individual's subordinate, and
 - (D) Will include a consultation with an independent health care professional with appropriate training and experience in the field of medicine if the review is being done to determine Medical Necessity.

This action must be taken within 180 calendar days of receiving an Adverse Determination of a claim that does not require Urgent Care, or the Claim Administrator's decision shall be the final decision of the Plan.

- (2) Within 30 calendar days of receiving an appeal (15 days for claims involving a Pre-Service Claim), the Medical Services Team will review the claim and provide a written determination on the appeal. The written decision will specify the reasons for the decision and will give specific references to the Plan provisions on which it is based:
 - (A) Specific reasons for the denial, and
 - (B) Specific references to pertinent Plan provisions on which the denial is based,

- and
- (C) A description of any additional material or information necessary to complete the claim, and an explanation of why such material is necessary, and
 - (D) An explanation of further appeals procedures, and
 - (E) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Covered Family Member's right to bring a civil action under the law following an Adverse Determination on review, and
 - (F) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, either such information; or a statement that such information was relied upon in making the Adverse Determination will be provided free of charge to the Covered Family Member upon request. Copies of all information relevant to the appeal will be made available to the Covered Family Member upon request, and
 - (G) If the Adverse Determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Covered Family Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- (3) If the Medical Services Team maintains the original denial and the Covered Family Member still does not agree, the Covered Family Member has 30 calendar days to appeal to the Plan Administrator. When resubmitting the claim to the Plan Administrator, include correspondence received from the Claim Administrator and any other information that may be appropriate.
- (4) Within 30 calendar days of filing the appeal with the Plan Administrator (15 days for claims involving a Pre-Service Claim), the Covered Family Member will receive a written decision. The Plan Administrator will either authorize the Claim Administrator to pay the claim or maintain the denial. The written explanation of the Plan Administrator's decision will cite the specific Plan provisions upon which the decision is based. The decision of the Plan Administrator is final.
- (5) No action at law or in equity will be brought to recover on the Plan until after proof of loss for a non-Urgent Care Claim has been filed with the Claim Administrator and the appeal process described above has been completed. No action will be brought at all unless brought within 24 months of the time within which proof of loss is required.

Physical Examinations: The Claim Administrator and the Plan Administrator have the right and opportunity to have any individual whose Sickness or Injury is the basis of a claim examined when and as often as it may reasonably require when such claim is pending. The findings of such examinations will not affect an Employee's or Dependents' Eligibility for continued enrollment under the Plan.

RESPONSIBILITIES OF THE PLAN ADMINISTRATOR

Named Fiduciaries: The named fiduciaries of this Plan shall be:

- (1) The Employer, and
- (2) The Plan Administrator.

The named fiduciaries shall have separate authority to control and manage the operation and administration of the Plan.

Advisors to Fiduciaries: A named fiduciary or his delegate may employ actuaries, attorneys, accountants, brokers, employee benefit consultants, and other specialists to give advice concerning any responsibility such fiduciary has under this Plan.

Appointment of Plan Administrator: The Plan Administrator is appointed by the Employer and approved by the Employer.

Duties of the Plan Administrator: The Plan Administrator has the authority and responsibility to:

- (1) Call and attend the meetings at which this Plan's contribution policy is established and reviewed, and
- (2) Establish the policies, interpretations, practices and procedures of this Plan, except to the extent such responsibility has been allocated to the Claim Administrator or retained by the Employer, and
- (3) Hire the Claim Administrator and all persons providing services to the Plan, and
- (4) Authorize payment of the Plan's administrative expenses, and
- (5) Transmit written instructions to the Employer concerning the management (including the acquisition or disposition) of insurance policies acquired to provide stop-loss coverage for the benefits provided under the Plan. The Plan Administrator shall be under no obligation to acquire such coverage on behalf of the Plan, and
- (6) Act as this Plan's agent for the service of legal process, and
- (7) Perform all other responsibilities allocated to the Plan Administrator in the instrument appointing the Plan Administrator, and
- (8) Comply with the requirements imposed upon the Plan Administrator under the COBRA continuation coverage provisions and applicable regulations, and
- (9) Comply with any reporting and disclosure requirements as required by law, and
- (10) Receive all disclosures required of fiduciaries and other service providers under federal or state law.
- (11) Comply with the HIPAA Privacy Regulation to ensure compliance with regard to the use and disclosure of any Covered Family Member's Protected Health Information.

If the Plan Administrator is a committee of two or more persons, the Employer is to appoint each member. Such committee shall act by a decision of a majority. When the membership of such committee is an even number and a majority decision cannot be obtained, the Employer shall decide the issue.

Discretion of Plan Administrator:

- (1) The Plan Administrator shall have the absolute authority and discretion to construe any uncertain or disputed term or provision in the Plan. This includes, but is not limited to, the following:
 - (A) Determining whether an individual is Eligible for benefits under this Plan, and
 - (B) Determining the amount of benefits, if any, an individual is entitled to under this Plan, and
 - (C) Interpreting all of the provisions of this Plan, and
 - (D) Interpreting all of the terms used in this Plan.

- (2) The Plan Administrator's exercise of this discretionary authority shall:
 - (A) Be binding upon all interested parties, including, but not limited to, the Covered Family Member, the Covered Family Member's estate, any beneficiary of the Covered Family Member and the Employer, and
 - (B) Be entitled to deference upon review by any court, agency or other entity empowered to review the Plan Administrator's decisions, to the fullest extent permitted by law, and
 - (C) Not be overturned or set aside on such review, unless found to be arbitrary and capricious, or made in bad faith.

If the Plan Administrator is a committee and if discretionary authority must be exercised against a member of the committee, the Plan Administrator's discretionary authority under this Plan must be exercised solely and exclusively by the other members of the committee. If the Plan Administrator is an individual, and discretionary authority is to be exercised against him as an individual, discretionary authority shall be exercised by an officer of the Employer.

Funding Policy: The Plan Administrator and Employer shall establish a funding policy and method consistent with the objectives of the Plan. The funding policy and method shall be reviewed at the Plan Administrator's discretion. In establishing and reviewing the funding policy and method, the responsible persons attending the meeting shall endeavor to determine the Plan's short-term and long-term objectives and financial needs, taking into account the need for liquidity to pay benefits. All actions taken pursuant to this section and the reasons for such action shall be recorded in the minutes of any meeting. Such minutes shall be filed with the Employer.

Plan Administrator Indemnity: To the extent permitted by the law and the Code in the event and to the extent not insured by any insurance company, the Employer shall indemnify and hold harmless the Plan Administrator and any assistants or representatives from any and all claims, demands, suits or proceedings in connection with the Plan that may be brought by Employees, Dependent(s), or their beneficiaries or legal representatives, or by any other person, corporation, entity, or government agency thereof; provided, however, that such indemnification will not apply to any such person for such person's acts of willful or grossly negligent misconduct in connection with the Plan, or for breaches of their fiduciary obligations or duties, as described under the law.

Co-Fiduciary Liability: No fiduciary shall have any liability for a breach of fiduciary duty of another fiduciary, unless he participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take action to remedy such breach, or, through his negligence in performing his own specific fiduciary responsibilities, he has enabled such other fiduciary to commit a breach of the latter's fiduciary duty.

RESPONSIBILITIES OF THE EMPLOYER

The Employer will have the Responsibility to:

- (1) Design this Plan, including the right to amend or terminate the Plan, and
- (2) Contribute to the Plan, and
- (3) Collect contributions, if any, as applicable and transmit those contributions to the claim account, and
- (4) Attend meetings at which this Plan's funding policy and method are established and reviewed, and
- (5) Appoint and remove the Claim Administrator, Plan Administrator and Privacy Officer, and
- (6) Pay the Plan's administrative expenses if such expenses are not paid from the claim account, and
- (7) Purchase stop-loss coverage if the Plan Administrator decides that such coverage is desirable. Neither the Plan Administrator nor the Employer shall be under any obligation to purchase such coverage on behalf of the Plan, and
- (8) Provide the Plan Administrator with payroll records and other data necessary for the performance of the Plan Administrator's responsibilities, and
- (9) Exercise all other functions necessary for the operation of this Plan, except those functions allocated to the Claim Administrator and Plan Administrator, and
- (10) Collect contributions, from participating employers, if any, that adopt this Plan for their employees.
- (11) Comply with the HIPAA Privacy Regulation to ensure Plan compliance with regard to the use and disclosure of any Covered Family Member's Protected Health Information.

Action by Employer: Any authority or responsibility allocated or reserved to the Employer under this Plan may be exercised by any duly authorized officer of the Employer.

Expenses: The costs and expenses incurred in the administration of this Plan shall be paid by the Employer. Such expenses shall include any expenses incident to the performance of a fiduciary's responsibilities, including, but not limited to, claim administration fees and costs, fees of accountants, legal counsel and other specialists, bonding expenses, and other costs of administering this Plan.

RESPONSIBILITIES OF THE PRIVACY OFFICER

Duties of the Privacy Officer: The Privacy Officer has the authority and responsibility to:

- (1) Ensure the compliance of all Plan Documents with the HIPAA Privacy Regulation.
- (2) Establish written policies and procedures for the Plan to ensure the privacy rights of Covered Family Members regarding Protected Health Information.
- (3) Establish a process to handle complaints by a Covered Family Member, including sanctions for employees and Business Associates who fail to comply with the Plan regarding the HIPAA Privacy Regulation.
- (4) Develop a Notice of Privacy Practices regarding Protected Health Information and distribute the notice to Employees Covered under the Plan.
- (5) Develop a program for training employees including certification that training has been completed.
- (6) Audit compliance with the HIPAA Privacy Regulation.
- (7) Ensure that the Plan does not use or disclose more than the minimum necessary Protected Health Information to carry out the intended purpose.
- (8) Identify the Plan's Business Associates and require a written agreement with the Plan's Business Associates that outlines their duties and responsibilities with respect to HIPAA and the Plan.
- (9) Maintain records and, when required, prepare an accounting of all uses and disclosures of Protected Health Information made outside of Treatment, Payment, or Health Care Operations. The record must contain an accounting of all disclosures for up to six years from the date of the first disclosure.
- (10) Allow the Covered Family Member access to view, copy and amend their Protected Health Information.
- (11) Discipline, sanction, or terminate any person for use or disclosure of any Protected Health Information outside of Treatment, Payment or Health Care Operations.
- (12) Mitigate the adverse effects of the unauthorized use of Protected Health Information.
- (13) Ensure continuing compliance with 45 Code of Federal Regulations, as it may be amended from time to time.

RESPONSIBILITIES OF THE CLAIM ADMINISTRATOR

Appointment of the Claim Administrator: The Claim Administrator shall be appointed by the Employer or the Plan Administrator.

Claim Administrator's Responsibilities: A Claim Administrator's authority and responsibility shall be limited to that portion of the Plan that it has been authorized by the Employer to administer. The Claim Administrator shall have the authority and responsibility to:

- (1) Interpret this Plan's provisions relating to coverage except where the Claim Administrator requests an interpretation, a claimant files an appeal with the Plan Administrator, or the Plan Administrator exercises its authority on its own volition. In said case, the Plan Administrator shall interpret the Plan and shall communicate in writing to the Claim Administrator the appropriate interpretation of the Plan.
- (2) Administer this Plan's claim procedure.

- (3) Pay benefits under the Plan by drawing checks against the claim account.
- (4) Advise or otherwise assist the Plan Administrator or Employer in connection with the purchase of stop-loss coverage, if any, for the benefits provided under the Plan.
- (5) File claims with the insurance companies, if any, who issue stop-loss insurance policies to the Employer.
- (6) Perform all other responsibilities delegated to the Claim Administrator in the instrument appointing the Claim Administrator.
- (7) Adhere to the HIPAA Privacy Regulation applicable to a Business Associate by complying with the provisions of the Business Associate agreement.

PARTICIPANT EMPLOYERS

Upon approval of the Plan Administrator and the Employer, other employers may arrange to have their employees participate in this plan, if such inclusion is not contrary to any applicable law.

In the event of such an arrangement, such an employer would be known as a participant employer for purposes of this Plan. The Plan Administrator will act for and on behalf of all participant employers in all matters pertaining to this Plan. Every act done by the Plan Administrator, agreement made between the Claim and the Plan Administrator, or notice given by the Claim Administrator to the Plan Administrator or by the Plan Administrator to the Claim Administrator shall be binding on all such employers.

In the event an employer terminates its participant employer arrangement under this Plan, such employer must still fulfill any obligations to the Plan Administrator or Claim Administrator with respect to the time the employer was a participant employer under this Plan.

PLAN INTERPRETATION

Word Usage: Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine or neuter form.

Court of Competent Jurisdiction: In the event that a court of competent jurisdiction shall determine in a final judgment or decree that one or more of the provisions of this Plan is invalid due to the provisions of applicable law, this Plan shall be interpreted as if the offending language had been stricken from its provisions and the remainder of the Plan shall continue in full force and effect.

STATEMENT OF RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the law. All Plan participants shall be entitled to:

Continue Group Health Plan Coverage: You have a right to:

- (1) Continue health coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Plan document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- (2) Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions, if applicable, under your group health plan, if you have creditable coverage from another health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Assistance With Your Questions: If you have any questions about your Plan, you should contact RMSCO Customer Service. If RMSCO Customer Service is unable to assist you, you should then contact the Personnel Department at Broome County. If you have any questions about this statement or about your rights under State law, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the State Insurance Department, listed in your telephone directory.

Qualified Medical Child Support Orders: The Plan provides medical benefits in accordance with the applicable requirements of any "Qualified Medical Child Support Order" as required under Federal law. A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a property settlement agreement) issued by either a court of competent jurisdiction or through an administrative ruling that has the force and effect of state law which:

- (1) Relates to the provision of child support with respect to the Child of an Employee or COBRA Beneficiary under this Plan or provides for health benefit coverage to such a Child, and is made pursuant to a state domestic relations law (including a community property law), and relates to such coverage under this Plan, or
- (2) Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to this Plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a beneficiary under this Plan. For purposes of this section, an "alternate recipient" shall mean any Child of an Employee or COBRA Beneficiary who is recognized by a Qualified Medical Child Support Order as having a right to enrollment under a group health plan with respect to such an Employee or COBRA Beneficiary, and
- (3) Satisfies the requirements of Federal law.

A procedure has been established to determine if a Qualified Medical Child Support Order exists. You may obtain a copy of the procedure at no charge from your Employer.

Newborns' and Mothers' Health Protection Act: Under this Federal law, sometimes referred to as the "NMHPA", certain requirements are imposed on group health plans that provide maternity or newborn infant coverage. Group health plans and health insurance issuers may not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery or less than 96 hours following a cesarean section.

However, the NMHPA does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

Women's Health and Cancer Rights Act: Under this Federal law, group health plans that provide medical and surgical benefits for mastectomies must provide coverage in connection with the mastectomy, in the manner determined by the attending physician and the patient for:

- (1) Reconstruction of the breast on which the mastectomy was performed, or
- (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance, or
- (3) Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Further, the law prohibits:

- (1) Penalizing or otherwise reducing or limiting the reimbursement of an attending Provider for the required care, or
- (2) Providing any incentive (monetary or otherwise) to induce the attending Provider to provide care that would be inconsistent with the law.

The above-described coverage required by the law may only be subject to the annual deductibles, Copayments, and Coinsurance provisions that apply to similar benefits.

Certification of Compliance with Privacy Regulations: A Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your Protected Health Information. A complete description of your privacy rights under HIPAA can be found in the Notice of Privacy Practices you received when you enrolled. A copy is available upon request from the Employer.

Under HIPAA you have certain rights with respect to your Protected Health Information, including but not limited to, the right to see and copy the information, receive an accounting of certain disclosures of the information and to amend the Protected Health Information under certain circumstances.

Protected Health Information that is used for Treatment, Payment or Health Care Operations may be disclosed without your written authorization. The Plan will only disclose the minimum necessary Protected Health Information permitted or required by law.

The following employees or classes of employees or other workforce members under the control of the Employer may be given access to Plan participants' Protected Health Information relating to Treatment, Payment, or Health Care Operations received from the Plan or a health insurance or Business Associate servicing the Plan:

- (1) The Plan Administrator, and
- (2) Staff designated by the Plan Administrator.

Protected Health Information that is not related to Treatment, Payment or Health Care Operations is protected by HIPAA and will not be used or disclosed without your written authorization unless required by law. The Covered Family Member must authorize the use or disclosure of Protected Health Information for employment-related actions or decisions and in connection with any other benefit or employee benefit plan.

The Notice of Privacy Practices includes a complete description of your privacy rights under this Plan. You may request a copy of the Notice of Privacy Practices from the Employer or the Privacy Officer.

If you believe your privacy rights have been violated, you may file a complaint with the Plan in care of the Privacy Officer. You may also file a complaint with the Secretary of the Department of Health and Human Services, Hubert Humphrey Building, 200 Independence Ave., S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

GENERAL PLAN INFORMATION

PLAN NAME: Broome County HMO Red Medical Plan

PLAN NUMBER: N/A

PLAN SPONSOR: Broome County
PO Box 1766
44 Hawley Street
Binghamton, NY 13902

EMPLOYER IDENTIFICATION NO.: 15-6000449

TYPE OF PLAN: Welfare Benefit Plan for Medical, Dental, Vision and Prescription Benefits

PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS: Robert Murphy
Broome County
PO Box 1766
44 Hawley Street
Binghamton, NY 13902
(607) 778-2402

SOURCES OF CONTRIBUTIONS: Broome County and its Employees contribute funds

TYPE OF ADMINISTRATION: Third Party Administrator:
RMSCO, Inc.
115 Continuum Drive
Liverpool, NY 13088

PLAN YEAR: Plan records are kept on a Plan Year basis beginning on January 1st and ending on December 31st.

SOURCE OF FUNDING: General corporate assets

STOP LOSS INSURANCE: A stop loss policy is not provided.

PARTICIPANT EMPLOYER: None

PRIVACY OFFICER: Robert Murphy
Broome County
PO Box 1766
44 Hawley Street
Binghamton, NY 13902
(607) 778-2402

Authority to Construe and Apply Plan Documents: To the full extent permitted by law, the Plan Administrator (and its designees) shall have the sole discretionary authority to:

- (1) Construe any uncertain or disputed term or provision of the Plan, and
- (2) Decide all questions concerning the Plan and their application (including, but not limited to, determining eligibility questions, benefit questions, and questions of fact and/or law).

The exercise of this discretionary authority shall be binding upon all interested parties, including, but not limited to, you, your estate and your beneficiaries.