



**MASTER PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

**CITY OF OGDENSBURG EMPLOYEE'S
HEALTH PLAN**

Administered by

POMCO[®]
GROUP | THE EXPERTS
IN SELF-INSURANCE

Here is your guide to obtaining the most comprehensive benefits from your health care plan.

Outlined are the important features of participating in the

City of Ogdensburg Employee's Health Plan,

informs you how to use your benefits and

hopefully answers your questions/concerns.

Please keep it for future reference.

If you cannot obtain the answers you need,

please call your Customer Service Department at the

toll free phone number 888-887-6626.

Or you can visit our website at www.benefitsoft.com.

We are here to assist you with any questions/concerns!

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INTRODUCTION

This document is a description of City of Ogdensburg Employee's Health Plan (the Plan). No oral interpretations can change this Plan.

Coverage under the Plan will take effect for an eligible Employee and designated dependents when the Employee and such dependents satisfy all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions and eligibility.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, cost management requirements, Medical Necessity, failure to timely file claims, or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document describes the Plan rights and benefits for covered Employees, Retirees and their covered dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Employees. All Active and Retired Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee as determined by union regulations:

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.
- (2) is a Retired Employee of the Employer.
- (3) is in a class eligible for coverage.

The Waiting Period is counted in the Pre-Existing Conditions exclusion time. Please contact your Human Resources Department to verify if this Waiting Period pertains to your position.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered Employee's spouse and unmarried children from birth to the limiting age of 19 years. The dependent children must be primarily dependent upon the covered Employee for support and maintenance. However, a dependent child will continue to be covered after age 19, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 25. When the child reaches either limiting age, coverage will end on the child's birthday. If the child does not maintain full-time status or graduates, coverage closes independent of limiting age.

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

The term "spouse" shall mean the person recognized as the covered Employee's husband or wife [of the opposite sex] under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include biological children living in the same household as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a biological parent remains married to the Employee and also resides in the Employee's household.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (2) A covered dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to dependent or dependent to Employee, and the person was covered under this Plan before the change in status, all amounts will be applied to the maximums. If a person covered under this Plan changes status from Employee to dependent or dependent to Employee and the person is covered continuously under the Plan before, during and after the change in status, credit will be given for deductibles.

If a person covered under this Plan changes status from Active Employee/dependent to Retired Employee/dependent, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums of the Retiree Plan.

If both mother and father are Employees, their children will be covered as dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for dependent coverage.

At any time, the Plan may require proof that a spouse or a child qualifies or continues to qualify as a dependent as defined by this Plan.

Failure to report enrollment changes could result in mispayment of Plan benefits. Should this happen, you may be required to reimburse the full amount of any benefit overpayment.

FUNDING

Cost of the Plan. Active Employees - The City of Ogdensburg shares the cost of Employee and dependent coverage under this Plan with the covered Employees. Retired Employees - Former Active Employees of the City of Ogdensburg who retired from employment under the formal written plan of the City of Ogdensburg elect to contribute to the Plan the required Retired Employee contribution.

The enrollment application for coverage may include a payroll deduction authorization. This authorization should be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator or the Union Contract. The Plan Administrator sets those rates for non-union Employees and the negotiated Union Contract sets the rate paid for those covered by that union. The Plan Administrator reserves the right to change the level of Employee contributions for non-union Employees.

PRE-EXISTING CONDITIONS

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan even if that coverage is still in effect. The Plan will reduce the length of the Pre-Existing Condition Limitation period by each day of Creditable Coverage under this or a prior plan; however, if there was a significant break in the Creditable Coverage of 63 days or more, then only the coverage in effect after the break will be counted.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

A Covered Person will be provided a certificate of Creditable Coverage if he or she requests one either before losing coverage or within 24 months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

All questions regarding the Pre-Existing Condition Limitation and Creditable Coverage should be directed to the Plan Administrator.

Covered Charges incurred under **Medical Benefits** for Pre-Existing Conditions are not payable unless incurred 12 consecutive months after the person's Enrollment Date. This time may be offset if the person has Creditable Coverage from his or her previous plan.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

Any charges, in connection with an Illness, made before the earlier of (a) the date you have been insured under this coverage for one year, and (b) the end of a period of 90 consecutive days during which there are no medical expenses in connection with the Illness. This exclusion only applies to Illnesses that require medical expenses during the 90-day period immediately before you became covered.

The Pre-Existing Condition does not apply to Pregnancy, to a newborn child who is covered under this Plan within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

A Pre-Existing Condition limitation can be applied to any individual after the end of the first 63-day period during all, of which the individual was not covered under any Creditable Coverage.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for Employee-only or dependent coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization, if applicable.

If the covered Employee already has dependent coverage, separate enrollment for a newborn child is required.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has dependent coverage is not automatically enrolled in this Plan.

Charges for covered nursery care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "**Timely Enrollments**" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY ENROLLMENT

The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period. If a person enrolls prior to the 15th of the month, coverage will be effective the first of the next month. If a person enrolls after the 15th of the month coverage would not begin until the first of the next full month, which could be up to 45 days depending on receipt of enrollment.

If two Employees (husband and wife) are covered under the Plan and the Employee covering any dependent children terminates coverage, the dependent coverage may be continued by the other covered Employee; no Waiting Period is required if coverage has been continuous.

LATE ENROLLMENT

An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

OPEN ENROLLMENT

At a time determined by the Plan Administrator, there will be an annual enrollment period. At that time, Covered Employees and their covered dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the Open Enrollment Period will become at a time determined by the Plan Administrator unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a spouse's employment. To the extent previously satisfied, coverage Waiting Periods and Pre-Existing Conditions Limits will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- (1) Individuals losing other coverage.** An Employee or dependent that is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:
 - (a)** The Employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

- (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
- (c) The coverage of the Employee or dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or Employer contributions towards the coverage were terminated.
- (d) The Employee or dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
- (e) For purposes of these rules, a loss of eligibility occurs if:
 - (i) The Employee or dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a Lifetime limit on all benefits.
 - (ii) The Employee or dependent has a loss of eligibility due to the Plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).
 - (iii) The Employee or dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
 - (iv) The Employee or dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
 - (v) The Employee or dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

- (a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered dependent of the covered Employee. In the case of the birth or adoption of a child, the spouse of the covered Employee may be enrolled as a dependent of the covered Employee if the spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the dependent enrolled in the Special Enrollment Period will be effective:

- (1) in the case of marriage, not later than the first day of the first month beginning after the date of the completed request for enrollment is received;
- (2) in the case of a dependent's birth, as of the date of birth; or
- (3) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled **Continuation Coverage Rights under COBRA**):

- (1) The date the Plan is terminated.
- (2) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the **Continuation Coverage Rights under COBRA**.)
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

- (4) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the employee and covered dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.
- (5) The earliest date the Employee has a claim that is denied in whole or in part because the Employee has met or exceeded a Lifetime limit on all benefits.

Continuation during Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation during Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations will not be imposed unless they were in effect for the Employee and/or his or her dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period or Pre-Existing Conditions provision.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their dependents covered under the Plan before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for

coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health Plan continuation.

When Dependent Coverage Terminates. A dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled **Continuation Coverage Rights under COBRA**):

- (1) The date the Plan or dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason, except death. (See **Continuation Coverage Rights under COBRA**.)
- (3) The date a covered spouse loses coverage due to loss of dependency status. (See the **Continuation Coverage Rights under COBRA**.)
- (4) On the first date that a dependent child ceases to be a dependent as defined by the Plan. (See the **Continuation Coverage Rights under COBRA**.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) If a dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.
- (7) The earliest date the dependent has a claim that is denied in whole or in part because it meets or exceeds a Lifetime limit on all benefits.
- (8) Your dependents enrolled in your family coverage at the time of an Employee's or Retiree's death will maintain Plan enrollment eligibility until the end of the contribution paid period. The Human Resources Department can provide full details concerning Survivor Dependent eligibility and Plan participation costs. (See the **Continuation Coverage Rights under COBRA**.)

SCHEDULE OF BENEFITS

Verification of Eligibility 888-887-6626

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

COMPREHENSIVE MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the **Defined Terms** section of this document.

The Plan is a plan which contains a Network Provider Organization.

PPO name: POMCO Allied Network
Address: 2425 James Street
Syracuse, NY 13206
Telephone: 888-887-6626

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called Network Providers. The Plan agrees to reimburse the Provider directly for Covered Services.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, upon request.

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

Coordination of Benefits

When services and supplies are rendered and billed by a Network or non-Network Provider and this Plan is the secondary payer of benefits according to the **Coordination of Benefits** provision and/or **Medicare Secondary Payer** rules, the following will apply:

Coordination of Benefits: All benefits will still apply.

Medicare: Network benefits are not available even if you choose a Network Provider for Covered Expenses.

Medical Benefits

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to **Covered Services, Plan Exclusions, and Definitions**.

Plan Features	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
Deductible per Calendar Year	\$ 65.00 or \$ 98.00 per individual \$130.00 or \$195.00 per family ----- Deductible is based on contract with Employer.	
Common Accident Deductible	Family \$ 65.00 or \$ 98.00 ----- Cumulative for two or more covered family members injured in the same accident. Only expenses due to that accident and applied against the Plan deductible count toward this limit. Expenses also count toward the Calendar Year deductible.	
Carry-over Individual Deductible	Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year.	
Percentage Coinsurance	Varied. Please see individual plan features for details.	
Out-of-Pocket Limit Excluding Deductible, per Calendar Year	\$260.00 per person	
Maximum Benefit Amounts (Lifetime)	\$1,000,000.00	
Second Surgical Opinion (Mandatory)	This mandatory program requires a phone call before specific non-Emergency surgical procedures are performed in-patient. Please contact the POMCO Benefit Management Program toll-free at 1-800-766-2648. A benefit reduction of 50% will be applied for non-compliance with this requirement.	

Preventative Care	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
Well Child Care and Immunizations (through age 18)	100% of Allowed Charge, no deductible applies ----- Includes labs, x-rays, exam, immunizations, hearing and vision tests. Guidelines of the NYS mandate apply.	
Routine Newborn Care (includes circumcision-if child is less than 30 days old)	100% of Allowed Charge, no deductible applies	
Routine Adult Care Over Age 50	100% of Allowed Charge, no deductible applies; \$50.00 yearly maximum ----- Includes exam, x-rays and labs. Immunizations, routine hearing and vision exams are not covered. Also, includes routine colonoscopy, routine bone mineral density measurement and tests, and routine prostate cancer screening.	
Routine Mammography Screening (schedule based on age and family history)	100% of Allowed Charge, no deductible applies	
Routine Annual GYN (age 18 and older) • Exam	\$8.00 at 100%. ----- Remainder at 80% of Allowed Charge, after deductible Maximum 2 per Calendar Year.	
• Pap Smear, Cytology Screening	100% of Allowed Charge, no deductible applies ----- Maximum 2 per Calendar Year.	
• Other Routine Testing	Not covered.	

Hospital and other Facilities Expense Benefits	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
Inpatient Acute Care General Hospital Services (facility charges)	100% of Allowed Charge, no deductible applies ----- Room and Board charge limited to actual semi-private rate. ICU charge limited to Hospital's ICU charge. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered. Maternity is covered the same as any other illness. Routine nursery care is covered.	
Certified Birthing Centers	100% of Allowed Charge, no deductible applies	
Inpatient Mental Disorder Care (facility charge) <ul style="list-style-type: none"> • General Hospital or Private Proprietary Psychiatric Facility • Hospital Mental Disorder Day /Night Care Center 	100% of Allowed Charge, no deductible applies first 120 days Additional Medically Necessary days allowable at 80% of Allowed Charge, subject to deductible	
Inpatient Alcohol & Substance Abuse <ul style="list-style-type: none"> • General Hospital or Certified Alcohol/ Substance Abuse Facility Program • Hospital Substance Abuse Day/Night Care Center 	100% of Allowed Charge, no deductible applies ----- Maximum 4 weeks per Spell of Illness; maximum 6 weeks per Calendar Year. This benefit includes inpatient Substance Abuse detoxification.	
Hospital Outpatient Care Services	Charges must be billed by the Hospital for its services and supplies. Physician charges are considered separately.	
Preadmission Testing (facility charge)	100% of Allowed Charge, no deductible applies	
Emergency Room (facility charge) <ul style="list-style-type: none"> • Accidental Injury (within 72 hours of accident) • Sudden and Serious Illness (within 48 hours of onset) • Other 	100% of Allowed Charge, no deductible applies ----- 100% of Allowed Charge, no deductible applies ----- 80% of Allowed Charge after deductible	
Surgery (facility charge)	100% of Allowed Charge, no deductible applies	
Radiation Therapy	100% of Allowed Charge, no deductible applies	
Chemotherapy	80% of Allowed Charge after deductible	
IV Therapy	80% of Allowed Charge after deductible	
Kidney Dialysis or Medicare Certified Dialysis Center	80% of Allowed Charge after deductible	
Physical Therapy	80% of Allowed Charge after deductible	
Respiratory/Inhalation Therapy	80% of Allowed Charge after deductible	
Speech Therapy	80% of Allowed Charge after deductible	
Cardiac Rehabilitation	80% of Allowed Charge after deductible	
Occupational Therapy	80% of Allowed Charge after deductible	

Hospital and other Facilities Expense Benefits	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
Diagnostic X-ray, Lab and Machine Tests	100% of Allowed Charge, no deductible applies	
Hospital Outpatient Clinic Visit	80% of Allowed Charge after deductible	
Other Outpatient Hospital Services and Supplies	80% of Allowed Charge after deductible	
Ambulance	\$50.00 per trip at 100% of Allowed Charge, no deductible applies Remainder at 80% of Allowed Charge after deductible Professional and volunteer ambulances are covered. Train, sea and air ambulances are not covered.	
Freestanding Ambulatory Surgical Center	100% of Allowed Charge, no deductible applies	
Skilled Nursing Facility (SNF)/Rehabilitation Facility Care	100% of Allowed Charge, no deductible applies Maximum 100 visits per Calendar Year.	
<ul style="list-style-type: none"> Inpatient Care 	100% of Allowed Charge, no deductible applies Maximum 100 visits per Calendar Year.	
<ul style="list-style-type: none"> Outpatient Care 	80% of Allowed Charge	
Home Health Care Agency Service and Supplies	100% of Allowed Charge, no deductible applies Maximum 40 visits per Calendar Year.	
Hospice Care Agency	100% of Allowed Charge, no deductible applies Maximum 180 visits within 6 months. Bereavement counseling is available. Inpatient Hospice services are limited to 5 days.	
Urgent Care Facility	100% of Allowed Charge, no deductible applies	

Medical/Surgical Services and Supplies	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
Acupuncture	Not covered	
Allergy Injections	\$80.00 at 100% per Calendar Year	
Allergy Office Visit	Remainder at 80% of Allowed Charge, after deductible	
Allergy Serum		
Allergy Testing		
Biofeedback	Not covered	
Blood Services	80% of Allowed Charge after deductible Excludes donated or replaced blood.	
Chemotherapy	80% of Allowed Charge after deductible	
Chiropractic Care	80% of Allowed Charge after deductible	
Consultations		
• Inpatient	80% of Allowed Charge after deductible	
• Mandatory Second Opinion	80% of Allowed Charge after deductible	
• Outpatient	80% of Allowed Charge after deductible	
• Voluntary Second Opinion	80% of Allowed Charge after deductible	
Contact Lens/Eyeglasses Following Intraocular/Cataract Surgery	80% of Allowed Charge after deductible	
Dental Care	See benefit for type of service rendered	
Diabetic Education	Not covered	
Diabetic Supplies/Equipment	Not covered	
Diagnostic Testing		
• Genetic	100% of Allowed Charge, no deductible applies	
• Independent	100% of Allowed Charge, no deductible applies	
• Laboratory	100% of Allowed Charge, no deductible applies	
• Machine Testing	100% of Allowed Charge, no deductible applies	
• Pathology	100% of Allowed Charge, no deductible applies	
• Professional Interpretation Charges	100% of Allowed Charge, no deductible applies	
• X-ray	100% of Allowed Charge, no deductible applies	
Dietary/Nutritional Services/Supplies and Counseling other than Morbid Obesity Treatment	Not covered	
Durable Medical Equipment	80% of Allowed Charge after deductible	
Emergency Room Visit		
• Accidental Injury or Sudden and Serious Illness	100% of Allowed Charge, no deductible applies	100% of Billed Charge
• Other	80% of Allowed Charge after deductible	
Food Supplements		
• Enteral Formulas and Modified Food Products	Not covered	
• Nutritional Supplements for Phenylketonuria and Related Disorders	Not covered	
Foot Care and Podiatry Services	80% of Allowed Charge after deductible Routine foot care is not covered. Foot orthotics are not covered.	
Hearing Aid/Exam	Not covered	
Inhalation Therapy	80% of Allowed Charge after deductible	

Medical/Surgical Services and Supplies	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
IV Therapy	80% of Allowed Charge after deductible	
Kidney Dialysis	80% of Allowed Charge after deductible	
Medical/Surgical Supplies	80% of Allowed Charge after deductible	
Mental Disorders - Outpatient Treatment Includes family therapy	50% after deductible. \$10.00 maximum payment. Does not apply towards Out-of-Pocket.	
Psych Testing	80% of Allowed Charge after deductible	
Nursing-Private Duty	Covered for medical necessity 80% of Allowed Charge after deductible	
• Inpatient	See Home Health Care benefit.	
• Outpatient	First 48 hours are not covered.	
Orthotics	80% of Allowed Charge after deductible	
Oxygen	80% of Allowed Charge after deductible	
Physician Visits	\$10.00 allowable at 100% Remainder at 80% of Allowed Charge, after deductible	
• Home		
• Inpatient/Facility	\$18.00 at 100%, remainder at 80% of Allowed Charge, after deductible	
• Day 1	\$12.00 at 100%, remainder at 80% of Allowed Charge, after deductible	
• Day 2	\$6.00 per day at 100%, remainder at 80% of Allowed Charge, after deductible	
• Days 3-365		
• Office	\$8.00 allowable at 100% Remainder at 80% of Allowed Charge, after deductible	
	Services must be given and billed by a covered healthcare Provider and found Medically Necessary according to Plan provisions in an office, clinic, home or elsewhere.	
Prosthetics	80% of Allowed Charge after deductible	
PUVA (Psoralen & Ultraviolet Radiation Light Therapy)	80% of Allowed Charge after deductible	
Radial Keratotomy	Not covered	
Radiation Therapy	80% of Allowed Charge after deductible	
Rehabilitation Therapy	80% of Allowed Charge after deductible	
• Cardiac Rehabilitation	80% of Allowed Charge after deductible	
• Occupational Therapy	80% of Allowed Charge after deductible	
• Physical Therapy	80% of Allowed Charge after deductible	
• Speech Therapy	80% of Allowed Charge after deductible	
• Vision Therapy	Not covered	
Smoking Cessation	80% of Allowed Charge after deductible	
Substance Abuse – Outpatient Treatment Includes family therapy	80% of Allowed Charge after deductible Maximum 20 visits per Calendar Year	
Surgical Charge Benefit	Basic Surgical Benefit Maximum \$1,500.00 combining charges for the surgeon, assistant surgeon and anesthesiologist per operative session. 20% of surgeon's allowance at 100% up to Basic Surgical Benefit Maximum.	
• Anesthesia	Remainder at 80% of Allowed Charge, after deductible. 20% of surgeon's allowance at 100% up to Basic Surgical Benefit Maximum.	
• Assistant Surgeon	Remainder at 80% of Allowed Charge, after deductible.	
• Surgeon	100% of surgical schedule up to Basic Surgical Benefit Maximum. Remainder at 80% of Allowed Charge, after deductible.	
• Maternity	See surgery benefit	
• Voluntary or Elective Abortion	Dependent daughters are not covered for Pregnancy. Not covered	

Medical/Surgical Services and Supplies	In-Network Benefits (PHCS Network)	Out-of-Network Benefits
• Voluntary or Elective Sterilization	See surgery benefit	
Therapeutic Injections	80% of Allowed Charge after deductible	
TMJ	Not covered ----- Limited allowance: Surgical charges for reduction of dislocations and excision of TMJs. Please Surgical Charge Benefit for allowance.	
Transplants	See benefit for type of service rendered ----- Transplant is not covered. Prescriptions, physician services and diagnostic tests are covered. Services will only be considered after one-year waiting period from date of transplant. Limited to \$15,000.00 per Calendar Year.	
Treatment of Morbid Obesity	See benefit for type of service rendered ----- Limited: Non surgical medically necessary services are covered.	
Wigs	Not covered	

Covered Drugs and Supplies	Network and Out-of-Network
Prescription Drug Benefit (Medco) (retail 90-day or mail order 90-day supply)	Deductible: \$35.00 or \$ 52.00 Individual \$70.00 or \$105.00 Family <i>Deductible does not apply towards out-of-pocket limit. Deductible is based on contract with Employer.</i> Out-of-Pocket \$140.00 per individual. Percentage payable per prescription, after deductible: 80% Generic Drug 80% preferred Brand Name Benefit includes coverage for: Contraceptives, Oral Impotence

MEDICAL PROCEDURE REVIEW - SECOND AND/OR THIRD OPINION PROGRAM

Certain medical, diagnostic, or surgical procedures are performed either inappropriately or unnecessarily.

In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition. In order to prevent unnecessary or potentially harmful surgical treatments, the mandatory second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure or medical or diagnostic procedure. The Plan requires a second opinion when any of the following procedures is recommended on an inpatient basis to a Covered Person:

Bunionectomy	Knee surgery (including excision of cartilage)
Cataract removal	Laminectomy
Cholecystectomy	Ligation & Stripping of veins
Coronary Bypass	Mastectomy (breast surgery)
Dilation & Curettage	Prostatectomy
Hemorrhoidectomy	Submucous Resection
Herniorrhaphy	Tonsillectomy/Adnoidectomy
Hysterectomy	

Failure to follow the procedure will reduce reimbursement received from the Plan.

If the Covered Person does not receive a second and/or third opinion as explained in this section, benefit payment for the charges billed by the surgeon and any related expenses related to the surgery will be reduced by 50% following satisfaction of the deductible amount.

As patterns of medical practice change, the specific procedures which require a second opinion also change. All Covered Persons can receive a list of procedures for which a second and/or third opinion is required. Please contact the Plan Administrator or the utilization review administrator for this list.

Before a Covered Person has a surgery performed that is on the list, the Covered Person must contact the utilization review administrator at:

POMCO
1-800-766-2648
the number listed on the Employee's ID card

to receive information on how to obtain a second and/or third opinion to confirm the need for the surgery.

These additional consultations must be performed by Physicians who are:

- (1) Board Certified Specialists in the area in which the operation is concerned; and
- (2) not financially associated with either the surgeon originally recommending surgery or, in the case of a third opinion, with each other.

If the second opinion does not confirm the need for surgery, a third opinion is allowed. Payment for X-rays and laboratory tests ordered or performed by the second or third specialists, plus the services of the specialist, will be paid in full, but not more than the usual, reasonable and customary charge set forth for the specified procedures.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

COMPREHENSIVE MEDICAL BENEFITS

Comprehensive Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the **Schedule of Benefits**.

This amount will not accrue toward the 100% maximum Out-of-Pocket payment.

Deductible Three Month Carryover. Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

Family Unit Limit. When the maximum amount shown in the **Schedule of Benefits** has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Deductible for a Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any amounts paid under **Basic Benefits** for the same services. Payment will be made at the rate shown under reimbursement rate in the **Schedule of Benefits**. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the Out-of-Pocket limit shown in the **Schedule of Benefits** is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded and not including the deductible) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the **Schedule of Benefits**. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

COVERED CHARGES

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

PREVENTIVE CARE

Covered Charges under **Medical Benefits** are payable for routine **Preventive Care** as described in the **Schedule of Benefits**.

Charges for Routine Well Child Care:

- **Well Newborn Nursery/Physician Care:** The benefit is limited to the Allowed Charges made by a Physician for the first routine pediatric care while the newborn child is Hospital-confined. Charges for covered routine Physician care will be applied toward the Plan of the covered parent or if enrolled as a dependent in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.
- **Routine Well Child Care** is routine care by a Physician that is not for an Injury or Sickness, to include health care visits and immunizations. Coverage is intended to be consistent with the clinical standards set forth by the standards set forth by New York State Insurance Law. If these standards change, the Plan will automatically cover the new recommended standards.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

- **Routine Adult Physical Exams**, to include screening tests. See Summary of Benefits for limitations.
- **Gynecological Exam and Pap Smear and Cytology Screening**; maximum 2 per Calendar Year. However, the other routine testing will not be allowed.
- **Routine Mammography** as recommended by a physician:
 - at any age for Covered Persons having prior history of breast cancer or whose mother or sister has a prior history of breast cancer;
 - a single baseline mammogram for Covered Persons aged 35-39; and
 - age 40 or over for Covered Persons; limited to once a year.

HOSPITAL AND OTHER FACILITIES

This benefit applies when a Hospital charge is incurred for the care of a Covered Person's Injury or Sickness and during a Hospital confinement that starts while that person is covered for this benefit.

Benefit Payment

Inpatient Hospital care. The medical services and supplies furnished by a Hospital or a Birthing Center.

- (1) **Benefits for room and board charges.** The Usual and Reasonable Charges for room and board are payable as described in the **Schedule of Benefits**.

The Plan pays the average semi-private rate for room and board charges by a Hospital or other covered inpatient health facility. If the inpatient facility does not have a semi-private rate, the rate shall be 80% of the room and board charges made by the facility for its lowest priced private room accommodations. If the facility has several semi-private rates, the prevailing, or the most common rate, shall be used.

Charges for an Intensive Care Unit stay are payable as described in the **Schedule of Benefits**.

Charges for a private room will be covered if a private room is deemed to be Medically Necessary.

- (2) **Benefits for special charges (miscellaneous charges).** The Allowed Charges for Hospital-billed medical services and supplies (other than room and board) and diagnostic x-rays and lab tests are payable.
- (3) **Coverage of Pregnancy.** The Allowed Charges for the care and treatment of Pregnancy are covered the same as any other Sickness. There is no coverage for a dependent child's pregnancy.

Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally 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 or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- (4) **Charges for Routine Nursery Care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible dependent and is neither injured nor ill.

The benefit is limited to Usual and Reasonable Charges for nursery care while the newborn child is Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Mental Disorders. Covered Charges for care, supplies and treatment of Mental Disorders will be subject to the benefit payment maximums shown in the **Schedule of Benefits**. Covered Charges for care, supplies and treatment of Mental Disorders will be limited as follows:

- All treatment is subject to the benefit payment maximums shown in the **Schedule of Benefits**.
- Physician's visits are limited to one treatment per day.
- Services must be given and billed by a medical doctor (psychiatrist) or a licensed clinical psychologist (Ph.D.), Physician's corporation or clinic for the services of a licensed psychiatrist, licensed clinical psychologist, or Masters of Social Work (M.S.W.).

Substance Abuse. Covered Charges for care, supplies and treatment of Substance Abuse will be subject to the benefit payment maximums shown in the **Schedule of Benefits** for services by a certified alcohol or Substance Abuse Facility (freestanding agency or facility or a Hospital center) for an approved plan of inpatient care.

Inpatient detoxification is considered under this benefit. However, detoxification coverage is limited to no more than seven days in a Calendar Year. Expenses for Inpatient Substance Abuse (alcohol or drug abuse) rehabilitation are covered separately from detoxification.

All treatment is subject to the benefit payment maximums shown in the **Schedule of Benefits**.

Physician's visits are limited to one treatment per day. Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

Outpatient Hospital services and supplies payable are:

- (1) **Preadmission testing service.** The **Medical Benefits** percentage payable will be for diagnostic lab tests and x-ray exams when:
 - (a) performed on an outpatient basis before a Hospital confinement;
 - (b) related to the condition which causes the confinement; and
 - (c) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable at 100% for Network services and 100% for non-Network services even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required. The deductible will also be waived for these tests.

- (2) **Outpatient emergency accident care and emergency medical care.**
 - (a) Emergency care for the initial treatment of traumatic bodily injuries resulting from an accident. Treatment must be rendered within 72 hours of the accident. This benefit includes 3 follow-up visits within 30 days of the accident.
 - (b) Care for the initial treatment of a Medical Emergency, as defined in this Plan, within 48 hours of the onset of the Medical Emergency.
- (3) **Outpatient surgical care.**
- (4) **Outpatient therapy services after an Injury or Sickness.**
 - (a) Radiation therapy.
 - (b) Chemotherapy.
 - (c) Dialysis in a Hospital or Medicare-certified dialysis center.
 - (d) Physical therapy.
 - (e) Respiratory therapy.
 - (f) Occupational therapy.
 - (g) Speech therapy.

(5) Outpatient diagnostic services.

- (a)** Diagnostic radiology, ultrasound, nuclear medicine, and necessary supplies.
- (b)** Laboratory and pathology.
- (c)** ECG, EEG, and other diagnostic medical and physiological medical testing procedures.

(6) Clinic services or supplies.

Ambulance charges. The Allowable Charges billed by a local land ambulance service for trips to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

Ambulatory Surgical Center, as defined, for outpatient surgery.

Skilled Nursing Facility (SNF) Care

Inpatient SNF Services. The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- (1)** the patient is confined as a bed patient in the facility;
- (2)** the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement;
- (3)** the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility;

Outpatient SNF Services.

- (1) Rehabilitative Therapy.** Benefits are available for outpatient physical therapy, cardiac rehabilitation, occupational, speech therapy and inhalation/respiration therapy rendered to improve function lost due to an Illness or Injury. Such care must be ordered by the attending Physician and rendered by Professional Healthcare Providers licensed to render such care. Refer to the **Schedule of Benefits** for benefit limits.
- (2) Other Outpatient Services and Supplies.** Benefits are available for other outpatient facility service or supplies when found Medically Necessary according to Plan provisions. Coverage includes all necessary supplies used during the covered treatment.

Home Health Care Services and Supplies. Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the **Schedule of Benefits**.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

Hospice Care Services and Supplies. Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months, and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the **Schedule of Benefits**.

- (1) Bed patient either in a designated Hospice Unit or in a regular Hospital bed;
- (2) Day care service provided by the Hospice Agency;
- (3) Home care and outpatient services provided by the hospice including intermittent nursing by a registered nurse or licensed practical nurse or by a Home Health Aide;
- (4) Physical, occupational, speech, and respiratory therapy;
- (5) Medical social services and nutritional services;
- (6) Laboratory, x-ray, chemotherapy, and radiation therapy when needed to control symptoms;
- (7) Medical supplies and drugs and medications considered approved for the patient's condition. Benefits are not payable if the drugs or medications are of an Experimental nature;
- (8) Durable Medical Equipment;
- (9) Medical care provided by the Hospice Physician or other Physician designated to render services by the Hospice Agency; and
- (10) Bereavement services must be furnished within six months after the patient's death.

During this period of acceptance, all the patient's medical services must be provided by or obtained through the Hospice Agency. All services must be billed by the Hospice Agency.

Urgent Care Facility. The Plan covers covered services and supplies provided by a legally operated emergency clinic or center for minor outpatient emergency medical care or emergency minor surgery. A qualified Physician, a registered nurse, and a registered x-ray technician must be in attendance at all times when the center is open. The center must have x-ray and lab equipment and a life support system on the premises. An outpatient Hospital emergency room does not qualify as an Urgent Care Facility.

MAJOR MEDICAL BENEFITS

Blood Services

Blood, including blood and blood derivatives that are not donated or replaced, blood transfusions, and blood processing when found Medically Necessary. Administration of these items is included.

Chemotherapy Benefits

This benefit applies when a chemotherapy charge is incurred for therapy that is performed as part of the care of a Covered Person's Sickness and while the person is covered for this benefit.

A chemotherapy charge is the Allowed Charge of a Physician for chemotherapy.

The type of drug for which benefits are provided is limited to anticancer drugs that are not in an Investigational or Experimental stage to include antineoplastic agents (such as anticancer drugs) or agents used to destroy microorganisms (such as antibiotic drugs).

Oral chemotherapy, subcutaneous injections or intra-muscular injections are not covered under this chemotherapy benefit.

Chiropractic Care

Spinal manipulation/chiropractic services by a licensed doctor of chiropractic (D.C.) for the detection or correction of the structural imbalance or subluxation in the human body to remove nerve interference resulting from, or related to distortion, misalignment or subluxation of or in the vertebral column. The therapeutic care must be directed at functional improvement (active treatment). Benefits will not be paid for any Maintenance Care or care to prevent worsening.

Consultations

A consultation is an examination requested by an attending Physician to obtain an opinion in the evaluation and management of an Illness or Injury. Benefits are not payable for consultation expenses when the consultant is part of the same medical or surgical group as the requesting Physician. If the consultant takes over the management (treatment) of the condition, subsequent management visits are not considered to be consultations.

- (1) **Inpatient Consultations.** Coverage is limited to one inpatient consultation per specialty for each inpatient stay.
- (2) **Outpatient/Office Consultations.** Coverage for outpatient or office consultations is provided for as many specialty opinions requested by the attending Physician as Medically Necessary.
- (3) **Second Opinion Consultation.** Benefits are available for patient-requested second opinion consultations before proceeding with a covered surgical procedure or treatment. The second opinion consultation must be given by a board-certified Physician specialist whose specialty is appropriate to consider the need for the proposed procedure. If the consulting specialist renders the procedure, consultation benefits are not payable. If you or your dependent seeks a third opinion, benefits will be provided on the same basis as the second opinion. Whether or not the second (or third) opinion agrees that procedure is necessary, the Plan will cover the second opinion consultation. It is the patient's decision whether to undergo the procedure.

Contact Lens/Eyeglasses

Initial contact lenses or glasses required following intraocular surgery or cataract surgery, or required to treat corneal disease. No other eyeglasses, contact lens or visual aids, or related exams are covered under this benefit.

Dental Care

Injury to, or care of mouth, teeth and gums. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under **Medical Benefits** only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to Sound Natural Teeth within 6 months of the Injury.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Reduction of dislocations and excision of Temporomandibular Joints (TMJs).

No charge will be covered under **Medical Benefits** for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Diagnostic Testing, X-Ray and Lab Charge Benefits – Basic Benefit

This benefit applies when diagnostic testing, X-ray and lab charges are incurred for X-rays and lab tests that are part of the diagnosis of a Covered Person's Injury or Sickness and while that person is both covered for this benefit and not Hospital confined.

Diagnostic testing, X-ray and Laboratory charges are the Usual and Reasonable Charges for X-rays and laboratory tests. Benefits are provided for diagnostic services required in the diagnosis of a condition due to Injury or Sickness consisting of:

- (1) Diagnostic X-ray services.
- (2) Diagnostic medical services such as cardiographic and encephalographic testing, radioisotopic studies and other procedures which may be approved when performed and billed by a Physician.
- (3) Pathology tests (laboratory tests) when performed, billed for or ordered by a Physician.
- (4) Allergy testing when performed and billed for by a Physician.

Coverage includes separate Physician's charges for interpretations of covered diagnostic services given by a Hospital, Skilled Nursing Facility or other covered facility.

Charges for the following will not be included:

- (1) Premarital exams;
- (2) Routine physical exams;
- (3) Exams performed as part of dental work, eye tests or fitting of lenses for the eye.

Durable Medical Equipment

Rental of durable medical or surgical equipment when ordered by the attending Physician and found Medically Necessary according to Plan provisions. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase.

The necessary repairs and maintenance of purchased equipment may be allowed, unless covered by a warranty or purchase agreement. Charges for delivery and service are not covered.

Foot Care and Podiatry Services

Benefits are available for treatment related to care of the feet. Coverage includes services or supplies rendered and billed by licensed Physicians (medical doctors, osteopaths or podiatrists) for conditions of the feet. Charges for routine foot care are covered for patients with severe systemic disorders metabolic, such as diabetes or peripheral-vascular disease. Services or supplies for foot Orthotics, orthopedic shoes or shoe inserts are not covered (please refer to **Plan Exclusions**).

Infertility

Diagnostic services rendered for Infertility evaluation only.

In-Hospital Physician's Care Benefits – Basic Benefit

This benefit applies when a medical charge is incurred for the care of a Covered Person's Injury or Sickness during a Hospital confinement that starts while the person is covered for these benefits.

Benefit Payment

The benefit payment for medical charges per day is limited to the "daily medical charge" limit. For a period of Hospital confinement benefit payment is limited to the "medical care maximum charge" limit. Both the daily medical charge limit and the medical care maximum are described in the Schedule of Benefits.

Medical Charge

A medical charge is the Usual and Reasonable Charge of a Physician for medical care performed while the Covered Person is Hospital confined. However, a medical charge will not include:

- (1) a charge for care not rendered in the presence of a Physician; or
- (2) a charge for care received on the day of or during the time of recovery from a surgical procedure. However, this limit does not apply if the care is for a condition that is unrelated to the one that required surgery.

Kidney Dialysis

Benefits are available for service or supplies related to outpatient kidney dialysis procedures given and billed by Physicians or Medicare-certified dialysis centers. Home self-dialysis is also covered when ordered by the attending Physician and home setting found medically appropriate according to Plan provisions. If you are on home dialysis, coverage includes related laboratory tests and consumable or disposable supplies needed for the dialysis. Equipment found Medically Necessary by the Claims Administrator may also be covered. Benefits are not payable for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, or air conditioning, or for convenience or comfort items.

Medical Supplies (Home Use)

Benefits are available for certain medical and surgical supplies used in the home when ordered by the attending Physician and found Medically Necessary according to Plan provisions. Items such as gauze pads, swabs, alcohol, deodorizers, and adhesive tape are not covered. Coverage is limited to the following items:

- (1) Ostomy bags and supplies required for their use.
- (2) Catheters and supplies required for their use.
- (3) Extensive surgical dressings necessary for conditions such as cancer, diabetic ulcers and burns.

Mental Disorders – Outpatient Treatment

Covered Charges for care, supplies and treatment of Mental Disorders will be subject to the benefit payment maximums shown in the **Schedule of Benefits**. Covered Charges for care, supplies and treatment of Mental Disorders will be limited as follows:

- All treatment is subject to the benefit payment maximums shown in the **Schedule of Benefits**.
- Physician's visits are limited to one treatment per day.
- Services must be given and billed by a medical doctor (psychiatrist) or a licensed clinical psychologist (Ph.D.), Physician's corporation or clinic for the services of a licensed psychiatrist, licensed clinical psychologist, or Masters of Social Work (M.S.W.).

Nursing Care

The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

The charges **for the first 48 hours** of covered services for private duty nursing in a Calendar Year are excluded.

- (1) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and care must be so intense that the Hospital or Skilled Nursing Facility staff could not be expected to render such care or the Hospital's ICU is filled or the Hospital has no ICU. Shortage of general nursing staff does not establish medical necessity for private duty nurses
- (2) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The charges covered for outpatient nursing care are those shown under **Home Health Care Services and Supplies** or billed by a certified or licensed visiting nurse agency or by a state or county visiting nurse service for professional nurse services.

Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

A licensed practical nurse will be allowed if the doctor certifies that a registered nurse is unavailable for an approved plan of skilled nursing care.

Skilled nursing must be needed to manage the care of acutely ill patients and must not be ordered primarily at the request of a family or household member.

Orthotics

The initial purchase, fitting and repair of Orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Foot Orthotics are not covered.

Oxygen

Oxygen and supplies for its administration when found Medically Necessary and appropriate for self-care home use.

Physician Care

The professional services of a Physician for evaluation and management or therapeutic medical visits in an office, outpatient Hospital, clinic, home, or elsewhere. Services must be given and billed by covered healthcare Providers and found Medically Necessary according to Plan provisions. Consultations, surgical and obstetrical procedures, Mental Disorder care, Substance Abuse care, podiatrist care or foot care, rehabilitation therapies, are covered separately.

Prosthetics

The initial purchase, fitting and repair of fitted Prosthetic devices which replace body parts. Replacement may be covered if there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

Radiation Benefits

This benefit applies when a radiation or chemotherapy charge is incurred for therapy that is performed as part of the care of a Covered Person's Sickness and while the person is covered for this benefit.

A radiation charge is the Allowed Charge of a Physician for x-ray, radium or radiotherapy treatment.

Radiation charges will not include charges for diagnostic or cosmetic procedures.

Rehabilitation Therapy

Benefit limits are described in the **Schedule of Benefits** for:

- (1) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. If the patient reaches maximum potential for significant and measurable improved function, or if care is found by the Claims Administrator to be Maintenance in nature, benefits will no longer be payable.
- (2) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (b) an Injury; or (c) a Sickness that is other than a learning or Mental Disorder. If the patient reaches maximum potential for improved, or age appropriate, function, benefits will no longer be payable.
- (3) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.
- (4) **Cardiac rehabilitation** for outpatient telemetric monitoring during exercise for cardiac rehabilitation rendered at a Hospital or free standing cardiac rehabilitation center. Services must be rendered by a Physician, or by a professional nurse trained in cardiac rehabilitation. Services must be ordered by the attending doctor and found Medically Necessary due to certain medical conditions, such as post valvular or congenital heart surgery; post heart transplants; dilated cardiomyopathy; coronary occlusion; post myocardial infarction; post bypass surgery or angioplasty; or stable angina. Care must be initiated within 12 weeks after other treatment for the medical condition ends. The plan of care must be approved for benefits by the Claims Administrator. The Claims Administrator may request medical records to evaluate the claim for Plan coverage.

This benefit is limited to expenses for telemetric monitored exercise for cardiac rehabilitation only. No other exercise programs are covered. Coverage is limited to frequency up to three times per week and up to a maximum 12 consecutive weeks for an approved plan of care. Related testing procedures such as stress tests will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits. Separate charges for use of exercise equipment are not covered.

- (5) **Inhalation Therapy** for short-term outpatient inhalation therapy when ordered by the attending Physician for therapy services given by certified licensed respiratory therapists or other qualified Provider. Custodial Care or Maintenance Care is not covered.

Smoking Cessation

Care and treatment for smoking cessation programs, including transdermal nicotine patches, nicotine gum and nicotine lozenges. A store receipt, the UPC and the top of the box showing the deterrent purchased will be required for reimbursement.

Substance Abuse – Outpatient Treatment

Covered Charges for care, supplies and treatment of Substance Abuse will be subject to the benefit payment maximums shown in the **Schedule of Benefits**. Covered Charges for care, supplies and treatment of Substance Abuse will be limited as follows:

- All treatment is subject to the benefit payment maximums shown in the **Schedule of Benefits**.
- Physician's visits are limited to one treatment per day.
- Services must be given and billed by a medical doctor (psychiatrist) or a licensed clinical psychologist (Ph.D.), Physician's corporation or clinic for the services of a licensed psychiatrist, licensed clinical psychologist, or Masters of Social Work (M.S.W.).

Surgical Charge Benefits – Basic Benefit

Surgical procedures will be paid up to the maximum amount shown in the Schedule of Operations. The maximum payable amount for a procedure or series of procedures can be obtained by the Covered Person upon request to the Claims Administrator.

- (1) The Maximum Benefit for a "series of procedures" means:
 - (b) all surgical procedures performed during any one continuous period in an operating room; or
 - (c) successive surgical procedures for the same cause or any related cause unless they are separated by three months, or in the case of an Active Employee, by return to Active Work on a full-time basis.
- (2) This rule applies when two or more procedures are performed at the same time and:
 - (a) in the same operative field; or
 - (b) through separate incisions. The benefit payment will be made only for the procedure that has the largest maximum payment amount shown in the Schedule of Operations.
- (3) This rule applies when two or more procedures are performed at the same time and:
 - (a) in different operative fields; or
 - (b) through separate incisions. The major procedures will be paid up to the Maximum Payment amount. The lesser procedures will be paid at a percentage of the Maximum Payment amount. This percentage is a part of the surgical payment rules of the Claims Administrator.
- (4) This rule applies when a bilateral procedure is performed at the same operative session in separate operative fields. The benefit will be 150% of the surgical procedure amount for the unilateral procedure.

Surgical Charge

A surgical charge is the Usual and Reasonable Charge for performing a surgical procedure. It may be the fee of the surgeon, the assistant surgeon or the anesthesiologist.

Assistant Surgeon

The Maximum Payment for all assistant surgeons for each surgical procedure is 20% of the surgeon's allowance. The surgeon's fee will be paid at 100% of the surgical schedule allowance and the remainder will be paid at 80% after the deductible.

Surgical Schedule

The Plan will pay up to the Surgical Schedule Allowance per procedure. The Maximum Benefit allowance is \$1500.00. The balance is then paid under **Major Medical**.

Surgical Procedure	Surgical Schedule Allowance
Appendectomy	\$ 236.00
Bronchoscopy, diagnostic	\$ 177.00
Cholecystectomy	\$ 254.00
Cystoscopy, diagnostic	\$ 29.50
Cystotomy with exploration	\$ 354.00
Esophagoscopy, diagnostic	\$ 177.00
Excision of bartholin gland or cyst	\$ 153.00
Excision of chalazion, single	\$ 29.50
Excision of lymph node	\$ 177.00
Excision nail and/or nail matrix, partial or complete e.g., ingrown or deformed nail, for Permanent removal	\$ 59.00
Excision of pilondial cyst	\$ 236.00
Excision of brain tumor	\$1,239.00
Exploratory laparotomy	\$ 283.00
Gastrectomy (total)	\$1,062.00
Hemorrhoidectomy, internal or external	\$ 236.00
Hernioplasty, inguinal, unilateral	\$ 236.00
Bilateral	\$ 354.00
Hysterectomy, abdominal (complete)	\$ 413.00
Vaginal with pelvic repair	\$ 466.10
Mastectomy, radical, bilateral	\$ 513.00
Radical, unilateral	\$ 237.50
Mastoidectomy, simple, unilateral	\$ 472.00
Maternity	
Normal delivery	\$ 400.00
Caesarean section	\$ 600.00
Ectopic pregnancy	\$ 350.00
Spontaneous termination	\$ 150.00
Routine care	\$ 30.00
Myringotomy, bilateral, under general anesthesia	
With tube, un-bi	\$ 147.00
Nephrectomy, with complete undertectomy	
All stages	\$ 590.00
Prostatectomy, perineal, subtotal	\$ 472.00
Suprapubic, one or two stages	\$ 472.00
Sigmoidoscopy, diagnostic, initial	\$ 29.50
Thyroidectomy, total or complete	\$ 566.40
Tonsillectomy and adenoidectomy	
Under age 13	\$ 118.00
Over age 13	\$ 177.00

Surgical Charge Benefits – Major Medical Benefit

This benefit applies when a surgical charge is incurred for a surgical procedure that is performed as the result of a Covered Person's Injury or Sickness and while that person is covered for this benefit after the Basic Benefit.

It may be the fee of the surgeon, the assistant surgeon or the anesthesiologist.

Care and treatment for voluntary surgical sterilizations are covered.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

- (1) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowed Charge for the primary procedures; 50% of the Allowed Charge for each additional procedure performed in the same area of the body or through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
- (2) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Allowed Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowed Charge for that procedure.

Assistant Surgeon

Charges for assistant surgeon services are covered when found Medically Necessary for performance of the covered procedure. The Maximum Payment for all assistant surgeons for each surgical procedure is 20% of the value listed for surgery.

Anesthesia

Benefits are available for administration of general anesthesia found Medically Necessary for covered surgical procedures. Coverage is limited to anesthesia administration by anesthesiologists and/or Certified Registered Nurse Anesthetists. The Plan will not pay charges for administration of anesthesia given by the surgeon, the assistant surgeon, or by a Hospital employee. Exception: Administration of anesthesia by a Dentist who performed the surgery is covered when the anesthesia is rendered during a covered oral surgical procedure. The allowance for anesthesia includes the usual patient consultation before anesthesia and the usual care after surgery. Anesthesia administration expenses are not covered if the surgery is not covered by the Plan.

Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions, for example: covered electroshock therapy.

Maternity

The Allowed Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally 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 or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are available for services by a Physician or certified nurse midwife for childbirth, cesarean section, and other maternity care rendered for you or your spouse. Expenses related to Pregnancy incurred by your dependent children are excluded. Coverage is not provided for expenses connected with elective abortion.

The Plan excludes service or supplies related to surrogate maternity care. The payment for childbirth, cesarean section will include the usual care given by a Provider before and after the obstetrical procedure (prenatal or postnatal care).

Reconstructive Surgery

The Plan covers care required to significantly restore tissue damaged by an Illness or Injury or for reconstructive surgery that is incidental to or follows surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive surgery because of a congenital disease or anomaly of a dependent child that has resulted in a functional defect.

Reconstructive mammoplasties will also be considered Covered Charges. The federally mandated mammoplasty coverage will include reimbursement for:

- (1) reconstruction of the breast on which a mastectomy has been performed,
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (3) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

Transplants

Organ transplant services will be covered, not including the transplant itself, under the Major Medical portion of the benefit program. The services would include applicable prescriptions, Physician services and diagnostic tests. The annual maximum is \$15,000.00. Such services would be considered after one year from the date of the transplant.

DEFINED TERMS

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

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a Full-Time basis.

Allowed Charge (or Allowed Expense, Allowed Fee) - The Usual, Reasonable, and Customary Charges as determined by the Claims Administrator for Covered medical services rendered and billed by a covered non-Network Provider. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. If Medicare is primary, the Allowed Charge could be based on Medicare's allowance or limiting charges. The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays. It must be operated according to the applicable laws of the jurisdiction in which it is located, or accredited by the Joint Commission for the Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Care, or approved by Medicare to render outpatient surgery services. If the center is part of a Hospital, it will not be considered an Ambulatory Surgical Facility.

Biomechanical Prosthetic Device is a Prosthetic device that utilizes a computer microchip, myoelectric technology or other similar technology to control movement or use.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

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

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

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is any person eligible and enrolled for benefits or coverage under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of more than 63 days. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in

walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice Dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Deluxe equipment is not allowable when standard equipment is available and medically adequate for the reported condition.

Disposable supplies may be allowed if required to operate the medical equipment.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is the City of Ogdensburg.

Enrollee or Covered Enrollee is an eligible Employee, Retiree, survivor spouse, or COBRA participant under whose Member ID number enrollment is made.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. The Plan Administrator shall 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 decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if 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; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, 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) if 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) if 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 as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean 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, service, 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.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee or Retiree and the family members who are covered as dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic Drug means a Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement (or convalescent nursing home/extended care facility/Skilled Nursing Facility); and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical social services; medical supplies; and laboratory services by or on behalf of the Home Health Care Agency.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Immediate Relative of patient or Enrollee - Any of the following:

- (1) Spouse of the patient or Enrollee;
- (2) Natural or adoptive parent, child or sibling;
- (3) Stepparent, stepchild, stepbrother or stepsister;
- (4) Father-in-law, mother-in-law, brother-in-law, or sister-in-law;
- (5) Grandparent or grandchild; or
- (6) Spouse of grandparent or grandchild.

Incurred means those services or supplies given to or received by a Covered Person. Such expenses shall be considered to have accrued at the time or date the service or supply is actually provided.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Licensed Clinical Social Worker is a licensed social worker with at least three years of post degree experience who has been certified by the New York State Board for Psychiatric Social Work or similar qualifications outside New York.

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

Maintenance Care - Care rendered and directed at relieving discomfort or preserving function secondary to conditions where further enhancement of function cannot be demonstrated or expected. Care that cannot be reasonably expected to lessen the patient's disability enabling him or her to leave an institution. Maintenance Care does not imply the absence of symptoms nor does it imply such services are not necessary. It implies care rendered to maintain a function and prevent the condition from worsening.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency - a serious medical condition or behavioral condition after the onset of acute symptoms that were sudden and of such severity and/or pain that a prudent person, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention could result

placing the person in serious jeopardy (or others, if severe behavioral condition), impairment to bodily function, dysfunction of any organ, or serious disfigurement.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical and dental services; is not conducted for research purposes; is not Experimental or Investigational or not of an educational nature; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Claims Administrator reserves the right to decide, in its discretion, if a service or supply is Medically Necessary.

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

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person. Alternatively, a BMI (body mass index) value greater than 39 may be used to diagnose Morbid Obesity.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with accidents in an automobile or other vehicle, as mandated under the applicable law.

Orthotics - An external appliance or device intended to correct any defect in form or function of the human body. This does not include, for example, eyeglasses or contact lenses, hearing aids, wigs, corsets, apparel, orthopedic shoes or shoe inserts, or supportive devices for the feet.

Out-of-Pocket means the patient liability portion of the percentage co-payment.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a Psychiatric Facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the City of Ogdensburg Employees' Health Plan, which is a benefits plan for certain Active Employees and Retired Employees of City of Ogdensburg and is described in this document.

Plan Participant is any Employee, Retiree or dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy, to a newborn child who is covered under this Plan within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

A Pre-Existing Condition limitation can be applied to any individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Prosthetics - The making and application of any artificial part that replaces all or part of a body part, organ or function lost or impaired as the result of disease or Injury. This does not include, for example, eyeglasses or contact lenses, hearing aids, wigs, orthopedic shoes or supportive devices for the feet.

Provider - Any legally licensed Physician or any physical therapist, speech therapist, certified or Licensed Clinical Social Worker (for Mental Disorder care), or other health care Providers giving a covered service ordered by a Physician. Any licensed independent laboratory, Hospital, Skilled Nursing Facility, Substance Abuse Facility, Hospice Agency, Home Health Care Agency; or other facility/agency included for Plan coverage. Coverage includes charges billed by Urgent Care Facilities, and other health centers or clinics for Covered Services given by covered Physicians or other healthcare Providers that would otherwise be covered by the Plan. Also, see definitions for certain Providers. To be covered, a Provider must meet Plan definitions and limitations, render a covered service within Plan limitations, be operating within the scope of their license, and operating according to the laws of the jurisdiction where services or supplies are given or delivered.

Psychiatric Facility: A private facility that has been approved by the Joint Commission on Accreditation of Healthcare Organizations as an inpatient facility for the treatment of Mental Disorder and is licensed by appropriate state agencies. A public (government-owned) mental health facility for the treatment of Mental Disorder.

Rehabilitation Facility means a facility established, equipped and operated, according to the applicable laws of the jurisdiction in which it is located to provide restorative therapy to disabled persons on an inpatient or outpatient basis. The facility must be approved by the Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or be a Medicare approved facility for Medicare Part A Skilled Nursing Facility benefits. See also Skilled Nursing Facility.

Retired Employee or Retiree is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital, long-term acute care facility or any other similar nomenclature.

Sound Natural Teeth are natural teeth that are fully restored to function; or do not have any decay; or that are not more susceptible to Injury than virgin teeth; or do not have significant periodontal disease.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Substance Abuse Facility - An agency or freestanding facility or a Hospital center that is certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) for the outpatient treatment of Substance Abuse (drugs and alcohol). For services given outside New York, the facility must be certified by a state agency similar to the New York State OASAS. If a state does not have a certification regulation, the facility must be approved by the Joint Commission on Accreditation of Healthcare Organizations for the outpatient treatment of Substance Abuse.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of a dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Tricare is the Department of Defense's health care program for members of the uniformed services, their families and survivors.

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.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the Provider of the care or supply and does not exceed the usual charge made by most Providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

To calculate reimbursements, the Plan will use the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Basic and Major Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered or the Pregnancy is the result of rape or incest.
- (2) **Air Ambulance.**
- (3) **Acupuncture.** Office visits, treatment, and related services and supplies rendered by an acupuncturist, whether or not licensed and regulated by a government agency.
- (4) **Anesthesia.** Services or supplies for the administration of anesthesia for any surgery or treatment that is not covered by the Plan.
- (5) **Automobile Insurance, No-Fault Auto Insurance** for which the Covered Person is eligible to receive benefits through mandatory no fault or fault automobile insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. This applies whether or not a claim is made for payment under that coverage. Benefits under this Plan will automatically be denied if the No-Fault Auto Insurance or other payer of motor vehicle liability coverage denies benefits due to its DWI or DUI exclusion, felony exclusions, as not Medically Necessary, or for late filing. Charges for services or supplies not paid by the no-fault coverage due to its maximum payment limits will be covered under this Plan to the extent Allowable Fees would have otherwise been payable by this Plan. **Note:** No-fault and motor vehicle liability coverage is considered another plan under the **Coordination of Benefits** provision of this Plan.
- (6) **Biofeedback.**
- (7) **Birth control.** Services or supplies related to family planning, oral contraceptives or other birth control devices.
- (8) **Circumcision.** If child is older than 30 days old.
- (9) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.
- (10) **Cosmetic.** Services or supplies connected with elective cosmetic surgery or treatment. Reversal of elective, cosmetic surgery will not be covered unless found to be Medically Necessary according to Plan provisions. Exception: Care required to significantly restore tissue damaged by an Illness or Injury or for reconstructive surgery that is incidental to or follows surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive surgery because of a congenital disease or anomaly of a dependent child that has resulted in a functional defect.
- (11) **Counseling/Analysis/Support Groups.** Services or supplies primarily directed at raising the level of consciousness, social enhancement, counseling limited to everyday problems of living such as marriage counseling, family counseling, pastoral counseling; gender identity counseling, sex therapy, or support groups.
- (12) **Custodial Care.** Services or supplies provided mainly as a rest cure, Maintenance or Custodial Care.
- (13) **Dental Care.** Services or supplies related to care or treatment of the teeth, gums or alveolar process, such as dental caries (tooth decay), extractions whether simple or surgical, periodontics, bridges, crowns, orthodontia, implants or other services considered to be dental, rather than medical, in nature. Exception: Charges by a Dentist or Physician for care otherwise considered

medical such as reduction of fractures of the jaw or facial bones, surgical correction of cleft lip, cleft palate, removal of stones from salivary ducts, bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues, treatment and surgery for joint disorders, freeing of muscle attachments. Limited dental care given for Accidental Injury to Sound Natural Teeth within 6 months following the accident; in no event will the Plan pay for the repair or replacement of dentures, crowns or other dental devices.

- (14) **Durable Medical Equipment/Braces/Prosthetics/Devices.** Services or supplies related to duplicate medical equipment, braces, Prosthetics or other devices or the replacement of Durable Medical Equipment, braces, Prosthetics or other devices due to loss, theft or destruction, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional. The purchase of Durable Medical Equipment that can be rented unless the length of time that the equipment will be needed makes the purchase less costly than the rental. The purchase or replacement of any Biomechanical Prosthetic Device. Specialized equipment when standard equipment is adequate for the patient's condition. Services or supplies related to durable equipment, braces, Orthotics, or splints that are primarily for athletic use.
- (15) **Educational/Cognitive/Therapy for Developmental/Birth Defects.** Services or supplies related to special education or cognitive therapy for any reason, or for occupational, physical, psychological or other therapy that is primarily directed at educational or mental or physical developmental for learning deficiencies, mental retardation, developmental disorders, birth defects, autism, spinal bifida, birth defects, educational or occupational deficits or perceptual and conceptual dysfunctions. This applies whether or not associated with manifest mental illness or other disturbances. Services or supplies considered remedial or educational. Services and supplies that any school system is required to provide under any law. This applies even if the Covered Person, parent or guardian does not seek provision of such services or supplies through the school system.
- (16) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (17) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (18) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/ Investigational or not Medically Necessary.
- (19) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.
- (20) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease). Orthopedic shoes, foot Orthotics or other supportive foot devices.
- (21) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- (22) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (23) **Government Facilities/Institutions.** Services or supplies received in an institution owned or operated by federal, state or local governments. However, benefits will be available for covered expenses for the following exceptions:
 - (a) Veterans Hospital for services and supplies that are unrelated to conditions resulting from military service in the USA armed forces.

- (b) State or local government owned acute care Hospital or Skilled Nursing Facility that customarily bills for its services.
 - (c) State or local government owned mental health facility.
 - (d) Government owned facility that otherwise meets Plan limitations for coverage as an outpatient alcohol or Substance Abuse treatment facility.
 - (e) USA military acute care Hospital or Skilled Nursing Facility for treatment of retired or inactive military personnel or their dependents or for the dependents of active military personnel.
 - (f) Any government facility, if the patient with a sudden and serious Illness or Injury is treated immediately at a government facility, because of its closeness, and the confinement is only as long as the emergency care is necessary or it is impossible to transfer the patient to another facility.
- (24) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- (25) **Hearing.** Services or supplies related to hearing aids, tinnitus masking devices (or similar devices), communication devices, and examinations to determine the need for, adjustments or repair of them. Exceptions: The initial hearing aid for hearing loss caused by a covered surgical procedure rendered to a patient while he is covered under the Plan; services covered under the well adult or well child sections of this Plan and F.D.A. approved cochlear implant will be covered under the Plan's Prosthetic benefit.
- (26) **Hospital/facility employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital, or Skilled Nursing Facility, or any inpatient facility where care is received and paid by the Hospital or facility for the service.
- (27) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (28) **Illegal care.** Services or supplies considered illegal according to the laws of the state of jurisdiction or according to federal law. Benefits will not be provided if these excluded services are obtained outside the USA even if these services are legal in the foreign country.
- (29) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (30) **Immediate Relative or self giving professional services.** Professional services performed by a person who ordinarily resides in the Covered Person's home, or self, or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (31) **Impotence.** Care, treatment, services, or medications in connection for treatment of impotence.

- (32) **Infertility.** Care, supplies, services and treatment for Infertility, artificial insemination, or in vitro fertilization, except for diagnostic services rendered for infertility evaluation.
- (33) **Military Service.** Services or supplies for which benefits are, or can be, provided due to related Illness or Injury arising from the past or present military service in the armed forces of any government or international authority.
- (34) **Missed Appointments/Phone Consultations/Forms/No Care Given.** Medical summaries, invoice preparation, completion of claim forms, or fees for missed appointments, telephone consultations, charges for standby services. Services or supplies not actually received by the patient or incurred by someone other than the patient unless specifically included in this Plan such as coverage limits for organ donors.
- (35) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (36) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.
- (37) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (38) **Non-traditional** medical services, treatments and supplies (e.g., alternative medicine) which are not specified as covered under this Plan.
- (39) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (40) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (41) **Not specified as covered.** Medical services, treatments and supplies which are not specified as covered under this Plan.
- (42) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Medically Necessary non-surgical charges for Morbid Obesity will be covered (i.e., office visits, lab testing, nutritional counseling, etc.).
- (43) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. Payment will not be made even if you or your dependents do not claim the entitled benefits.
- (44) **Orthopedic Shoes/Orthotics (foot).** Charges in connection with supportive devices for the feet, and any expenses incurred in connection with treatment of conditions of the foot, except as otherwise specifically proved. Foot Orthotics are not covered.
- (45) **Other Plan/Benefit Penalties/Primary Care Network/HMO Network.** Services or supplies to the extent such expenses were disallowed by a primary health Plan due to failure by their Enrollee or participant to follow the requirements of its benefit management or managed care program, preadmission reviews, second surgical opinion, or any other reason, including failure to abide by the primary care Physician network established by a health maintenance organization that is a primary plan payer. P 35

- (46) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, support stockings, non-Prescription Drugs and medicines, first-aid supplies and non-Hospital adjustable beds, as well as telephone, radio, television, or barber services charged by any facility or other Provider.
- (47) **Plan design excludes.** Charges excluded by the Plan design as specified in this document.
- (48) **Police Custody/Court Ordered Services.** Services or supplies incurred while the Covered Person is in police custody, jail or in prison, or services or supplies related to court ordered evaluations for Mental Disorders or substance (drug and alcohol) abuse.
- (49) **Pregnancy of daughter.** Care and treatment, including complications, of Pregnancy for a dependent daughter only.
- (50) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the **Schedule of Benefits**.
- (51) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (52) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (53) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (54) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
- (55) **Subrogation/Third Party Claim.** Services or supplies for which payment is received or are reimbursable because of claim settlement or legal action (third party claim or actions) other than from an insurance carrier under an individual policy issued to you or your dependent. Exception: Conditional payments shown in the section entitled "**Third Party Recovery Provision**".
- (56) **Surgical Assistance.** Expenses billed for surgical assistance in a Hospital if the Hospital has qualified staff Physicians to provide such assistance. Expenses billed for surgical assistance by Providers other than qualified surgeons (M.D., D.O., or a D.P.M for foot surgery, or a D.D.S., D.M.D.) for covered oral surgery.
- (57) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilizations.
- (58) **Surrogate Pregnancy.** Services or supplies related to surrogate maternity care, including but not limited to, those needed to initiate a Pregnancy, prenatal care, delivery or other procedures, and postnatal care or any other related care of the Pregnancy. Benefits are available for newborns who meet the child eligibility requirements and who are enrolled under family coverage.
- (59) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge or transportation services specifically listed in this Plan.
- (60) **War.** Any loss that is due to a declared or undeclared act of war.
- (61) **Wigs.**

PRESCRIPTION DRUG BENEFITS

Covered Drugs and Supplies	Network and Out-of-Network	Covered Drugs and Supplies
Deductible per Calendar Year (retail 90-day or mail order 90-day supply)	\$35.00 or \$52.00 per individual \$70.00 or \$105.00 per family	
	<i>Deductible is based on individual's contract with Employer. Please check contract to determine which deductible applies. Deductible does not apply towards your Out-of-Pocket.</i>	
Out-of-Pocket Limit Excluding Deductible, per Calendar Year	\$140.00 per Individual	
Pharmacy Option	Generic drugs Percentage payable 20% Brand Name drugs Percentage payable 20%	
Mail Order Prescription Drug Option	Generic drugs Percentage payable 20% Brand Name drugs Percentage payable 20%	

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Medco is the administrator of the Pharmacy drug plan.

Percentages Payable

The percentage payable amount is applied to each covered Pharmacy drug or mail order drug charge and is shown in the **Schedule of Benefits**. This amount is not a Covered Charge under this Plan or the medical plan. Any one Pharmacy prescription is limited to a 90-day supply. Any one mail order prescription is limited to a 90-day supply.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, Medco by Mail, the mail order Pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

Covered Prescription Drugs

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician. Other injectables are not covered.
- (4) Retin-A for the diagnosis of acne, under age 36.

Quantity Limits

- (1) Thalomid, up to 28-day supply
- (2) Pediatric Fluoride Vitamins Drops, up to a 50-day supply

Limits to This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants/dietary/vitamin supplements.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription, including contraceptive devices. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids or medications for hair growth or removal.
- (6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.
- (9) **Immunization.** Immunization agents or biological sera.
- (10) **Infertility.** A charge for Infertility medication.
- (11) **Injectable.** A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than for insulin).
- (12) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (13) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".
- (14) **Medical exclusions.** A charge excluded under **Medical Plan Exclusions.**

- (15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (17) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
- (18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (19) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent patches, for smoking cessation.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Network Provider benefits are always paid directly to the Network Provider. Benefits for Hospital or other facility are generally paid directly to the Hospital or facility, if charges have not been paid by you. All other Allowed Charges/benefits are generally paid directly to you unless you direct payment to the Provider with written authorization.

When the claim is processed, POMCO will send you an Explanation of Benefits Statement attached to your benefit payment (if applicable). This information should be carefully reviewed to make sure the charges were submitted to POMCO correctly and that the claim was processed accurately.

When a Covered Person has a Claim to submit for payment that person must:

- (1) Obtain a Claim form from the Personnel Office or the Plan Administrator.
- (2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- (3) Have the Physician or Dentist complete the Provider's portion of the form.
- (4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
 - Name of Plan
 - Employee's name
 - Member ID number
 - Name of patient
 - Name, address, telephone number of the Provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of services
 - Charges
- (5) Send the above to the Claims Administrator at this address:

POMCO
2425 James Street
Syracuse, New York 13206
888-887-6626

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 6 months of the date charges for the service were Incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless

- (1) it's not reasonably possible to submit the claim in that time; and
- (2) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

- (1) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Member ID number, the name of the patient and the Group Identification Number, if any.
- (2) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Claims Administrator within 180 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Claims Administrator and the Claims Administrator will provide the Plan Participant with a written response within 60 days of the date the Claims Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Claims Administrator is unable to complete the review process within 60 days, the Claims Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Claims Administrator received the Plan Participant's written request for review.

The Claims Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

If the Plan Participant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's spouse is covered by this Plan and by another plan or the couple's covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses. Exception: See also **Medicare Integration** described below.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network Provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the covered person does not use an HMO or network Provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the covered person used the services of an HMO or network Provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

For Medicare integration, see section below.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles p36. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

- (b) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (c) The benefits of neither a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
 - (d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
 - (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.
 - (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
 - (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.
 - (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
 - (5) The Plan will pay primary to Tricare to the extent required by federal law

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

MEDICARE

If Medicare is primary for you or your dependent, the benefits of the Plan will be integrated as follows:

(1) Medicare Payment Integration.

The Plan determines the allowable fee first, and then pays the difference between the allowable fee and Medicare's payment up to the lesser of the balance of the bill or the Plan's normal benefit.

(2) Not enrolled in Medicare. This integration will apply to persons eligible for Medicare whether or not actually enrolled in Medicare or incurs services in a Veterans Administration Hospital/federal facility.

If Medicare is primary for an eligible person who is not enrolled in Medicare Part A and Part B or in Part C, the Medicare benefit will be estimated and used to reduce Allowable Fees. This could result in significant reduction or denial of the Plan benefits. Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated, based on 80% of Usual, Reasonable and Customary Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits.

For services Incurred in a Veterans Administration Hospital/federal facility which are not billable to Medicare, benefit integration will be estimated. Part A services will be estimated according to Medicare payment rules. Part B will be estimated, based on 80% of Usual, Reasonable and Customary Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits.

(3) Medicare Private Contract Options. This integration will apply to persons eligible for Medicare primary benefits if Medicare benefits are not paid due to a Medicare Private Contract Option with Physicians and certain other practitioners. (When a Medicare beneficiary agrees to the terms of a Private Contract with certain Providers, Medicare will not pay. The patient is responsible for the entire charge. The Provider may bill more than the charges allowed by Medicare.) Under this Plan, if a private contract is used, Medicare benefits will be estimated. Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated, based on 80% of Usual, Customary and Reasonable Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits. The estimated Medicare benefits will be used to coordinate benefits. This could result in significant reduction or denial of the Plan benefits.

(4) Medicare Part C (Medicare Advantage). This integration will not apply when Medicare and a Medicare-sponsored Advantage Plans deny coverage due to its enrolled beneficiary's failure to abide by the HMO or Participating Provider Program requirements. This Plan will not cover the expenses for those services or supplies and Plan benefits will not be paid.

ALLOWABLE FEES

Allowable Fees for Medicare integration only will be based on the following:

- (1)** If the Provider accepts Medicare assignment of benefits, the Allowable Fees will be the same fees allowed by Medicare.
- (2)** If the Provider does not accept Medicare assignment, the Allowable Fees will be based on the Usual, Reasonable and Customary Charges for non-Network Providers, the Network allowance for Network Providers or the charges determined by Medicare limiting charge regulations, whichever is the lower charge.
- (3)** If the Provider provides services under a Medicare Private Contract Option, Allowable Fees will be based on the Usual, Reasonable and Customary Charges or the Network allowance, if applicable for services covered by this Plan.

According to Medicare regulations, a beneficiary cannot be billed the difference between the Medicare allowed amounts and the Provider's charges when that Provider accepts Medicare assignment. If a Provider does not accept assignment, a beneficiary cannot be billed for charges over the limiting charge established by Medicare for that service by that Provider. However, if services are provided under the Medicare Private Contract Option, the Provider's charges can exceed the Medicare allowable fees.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
- (2) cannot assign any rights against any Third Party or insurer without express written consent of the Plan; and
- (3) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits Incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under City of Ogdensburg Employees' Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is City of Ogdensburg, 330 Ford Street, Ogdensburg, New York 13669, telephone 315-393-1860. COBRA continuation coverage for the Plan is administered by First Niagara Risk Management, 7481 Henry Clay Blvd., Liverpool, New York 13088, 315-461-1282. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the spouse of a covered Employee, or a dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the spouse, surviving spouse or dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the spouse, surviving spouse or dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's spouse.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered spouse or a dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the spouse, or a dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having Pre-Existing Condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such Pre-Existing Condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain Retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the Employee,
- (3) commencement of a proceeding in bankruptcy with respect to the Employer, or
- (4) enrollment of the Employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

City of Ogdensburg
330 Ford Street
Ogdensburg, New York 13669

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

- (5) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered Retiree ends on the date of the Retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered spouse, surviving spouse or dependent child of the Retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the Retiree.
- (4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month

period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Sponsor.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. City of Ogdensburg Employees' Health Plan is the benefit plan of City of Ogdensburg, the Plan Administrator, also called the Plan Sponsor.

An individual may be appointed by City of Ogdensburg to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, City of Ogdensburg shall appoint a new Plan Administrator as soon as reasonably possible.

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

Service of legal process may be made upon the Plan Administrator.

Duties of the Plan Administrator.

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

Plan Administration Compensation. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

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

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

MISREPRESENTATION/FRAUD

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

REFUND DUE TO OVERPAYMENT OF BENEFITS

If payment has been made for Covered services or supplies under the Plan that are more than the benefits that should have been paid, or for services or supplies that should not have been paid, according to Plan provisions, the Plan Administrator or the Claims Administrator shall have the right to demand a full refund, or may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such Covered Person or other present or future amounts payable to such person, or recover such amounts by any other appropriate method that the Plan Administrator, in its sole discretion, shall decide. Each Covered Person hereby authorized the deduction of such excess payment from such benefits, or other present or future benefit payments.

Payments made in error for services or supplies not covered by this Plan shall not be considered certification of coverage and will not limit the enforcement of any provision of this Plan for any and all claims submitted under the Plan.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

HIPAA COMPLIANCE

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees and Retired Employees. The Plan is not insured.

PLAN NAME: City of Ogdensburg Employees' Health Plan

PLAN NUMBER: 3005

TAX ID NUMBER: 156000410

PLAN EFFECTIVE DATE: January 1, 1979

RESTATEMENT DATE: January 1, 2008

PLAN YEAR ENDS: December 31st

EMPLOYER INFORMATION: City of Ogdensburg
330 Ford Street
Ogdensburg, New York 13669
315-393-1860

PLAN ADMINISTRATOR: City of Ogdensburg
330 Ford Street
Ogdensburg, New York 13669
315-393-1860

CLAIMS ADMINISTRATOR:
Health: POMCO
2425 James Street
Syracuse, New York 13206
888-887-6626
www.pomcogroup.com

Prescription drugs: Medco
PO Box 2187
Lee's Summit, MO 64063-2187
800-818-6632
www.medco.com

BY THIS AGREEMENT, City of Ogdensburg Employees' Health Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for City of Ogdensburg on or as of the January 1, 2008.

By _____

HIPAA PRIVACY AMENDMENT

CITY OF OGDENSBURG EMPLOYEES' HEALTH PLAN

BY THIS AGREEMENT, City of Ogdensburg, the medical and Prescription Drug plan(s) (herein called the "Plan") are hereby amended as follows, effective as of 01/01/2008.

City of Ogdensburg ("Employer") sponsors a group health plan(s) known as medical and Prescription Drug plan(s) for the benefit of its eligible Employees and their dependents.

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the Employer is amending the Plan as follows:

1.1 General. The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Amendment is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

1.2 Permitted Uses and Disclosures. Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care Providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

1.3 Authorized Employees. The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated on Schedule I hereto attached and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this Amendment, "members of the Employer's workforce" shall refer to all Employees and other persons under the control of the Employer.

(a) Updates Required. The Employer shall amend Schedule I promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) Use and Disclosure Restricted. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) Resolution of Issues of Noncompliance. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Amendment and the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

- (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
- (iii) Mitigating any harm caused by the breach, to the extent practicable; and
- (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

1.4 Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
- (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer;
- (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;
- (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in Section 1.3 hereof.

IN WITNESS WHEREOF this Agreement has been executed on behalf of City of Ogdensburg, a corporation on 01/01/2008.

By _____