

Traditional Plan
Broome County
Health Plan
Revised August, 1995

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INTRODUCTION

This document is a description of Broome County Health Plan (the 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.

Broome County fully intends to maintain this Plan indefinitely. However, the County reserves the right to terminate, suspend, discontinue or amend the Plan at any time upon advance notice to all Participants, subject to any restrictions in effect pursuant to collective bargaining agreements.

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

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

Important Plan Information

The **Plan Administrator** is the County of Broome, Risk and Insurance Department, Broome County Office Building, PO Box 1766, Binghamton, NY 13902.
Telephone: (607) 778-2402

To verify coverage under this Plan or if you have any questions about your claims, contact the Claims Administrator :
RMSCO INC. , P.O. Box 6309, Syracuse, NY 13217-6309.
Telephone (877) 300-7343

To verify benefit coverage for services that are subject to managed care review, contact the Managed Care Administrator:
Corporate Care Management, Inc., 1 Kattelville Road, Binghamton, NY 13901.
Telephone (607) 648-3400 or (800) 541-7403.

This document summarizes the Plan rights and benefits for covered Employees and their 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 a brief outline of the Plan reimbursement formulas as well as payment limits on certain services. Refer to Benefit Descriptions for more detailed descriptions of benefits.

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

Benefit Limits. Shows the limits applicable for certain conditions or treatment methods.

Managed Care Services. Explains the methods used to verify medical necessity and maximize Plan benefits.

This part should be read carefully since certain Participants are required to take action to assure that the maximum payment levels under the Plan are paid.

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.

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.

COBRA Continuation Options. 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 Broome County who satisfy the following condition:

Eligibility Requirements For Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

- (1) is a Full-Time, Active Employee of Broome County or Broome Community College. An Employee is considered to be Full-Time if he or she normally works at least 37.5 hours per week; or
- (2) is a Part-Time, Active Employee of Broome County (Part-Time employees of Broome Community College are not eligible for this Plan). An Employee is considered to be a Part-Time Employee of Broome County if he or she normally works at least 18.75 hours per week; or
- (3) is a Retired Employee (as defined in this Plan) who was a former Active Employee of Broome County. Employees who retire on disability or who become disabled after retirement are required to apply for Social Security disability and Medicare benefits as soon as they may be eligible for these benefits; or
- (4) is a temporary Full-Time ESPA employee or Full-Time adjunct employee of Broome Community College who has completed four consecutive months of service; and is in a class of employees eligible for coverage.

Eligible Classes of Dependents

I. An eligible dependent is any one of the following persons:

- (1) A covered Employee's Spouse and unmarried children from birth to the 19th birthday. However, a Dependent child will continue to be covered after age 19, provided that the child is:
 - (a) a full-time student at an accredited school,
 - (b) primarily dependent upon the covered Employee for support and maintenance,
 - (c) unmarried, and
 - (d) under age 25.

When the child reaches the limiting age, coverage will end on the child's birthday. For dependent children whose coverage has been extended as full-time students, coverage will end on the last day of the month during which they cease to qualify for the dependent student extension.

The term "Spouse" shall mean the legally recognized marital partner of a covered Employee. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children, adopted children or children residing with a covered Employee in anticipation of adoption. A child shall not be deemed to reside with adoptive parents any earlier than the date of the child's discharge from the hospital after birth. Step-children who permanently reside in the Employee's household may also be included.

As required by the Federal Omnibus Budget Reconciliation Act of 1993, 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 with no Pre-Existing Conditions provisions applied.

- (2) A covered Dependent child who is age 19 or over and who is:
- (a) incapable of self-sustaining employment by reason of mental retardation or physical or psychological handicap,
 - (b) primarily dependent upon the covered Employee for support and maintenance,
 - (c) unmarried,
 - (d) covered under the Plan and disabled when reaching the limiting age, and
 - (e) determined to be disabled by the Social Security Administration within six months of reaching the limiting age.

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.

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 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 divorced former Spouse of the Employee; or any person who is on active duty in any military service of any country.

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. The Employee is required to notify the Plan within 31 days of a dependent's change in status under the Plan (e.g., dependent student extension, divorce).

FUNDING

Cost of the Plan

County of Broome shares the cost of Employee and Dependent coverage under this Plan with the covered Employees.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions, subject to any applicable collective bargaining agreements.

ENROLLMENT

Enrollment Requirements

An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is required to enroll for Dependent coverage also, including coverage for newborn children.

Enrollment Requirements for Retirees

Retirees are required to enroll for Medicare Part B coverage as soon as they are eligible for Medicare. Employees who retire on disability or who become disabled after retirement are required to apply for Social Security disability benefits at the time of the disability and apply for Medicare benefits as soon as they are eligible for Medicare. This Plan will pay benefits for Retirees who are eligible for Medicare, less any 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.

Enrollment Requirements for Newborn Children

For coverage of Illness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, the newborn child must be enrolled as a Dependent under this Plan within 31 days of the child's birth in order for coverage to take effect from the date of birth.

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

Timely or Late Enrollment

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after
 - (a) the person becomes eligible for coverage, or
 - (b) a qualified family status change as defined in the Broome County Flexible Benefit Plan and Internal Revenue Code Section 125.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other Covered Employee with no waiting period as long as coverage has been continuous.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis". In the case of a late enrollment, enrollment will be deferred until the next open enrollment period and coverage will become effective on January 1 of the next calendar year.

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 Actively at Work Requirement.
- (3) The Enrollment Requirements of the Plan.

Actively at Work Requirement

Active Employees - An Employee must be Actively at Work for coverage under the Plan to take effect. An Employee will be considered Actively at Work if the Employee is performing the regular duties of employment on that day either at Broome County's place of business or at some location to which the Employee is required to travel for Broome County's business.

An Employee is considered to be Actively at Work on each day of a regular paid vacation, on an approved leave of absence, and on each regular non-work day on which the Employee is unable to perform the essential functions of his or her job, if the Employee was Actively at Work on the last preceding regular work day.

If an Employee is absent from work due to the inability to perform the essential functions of his or her job on the date this Plan would otherwise have been effective, the effective date will be deferred until the date on which the Employee returns as an Active Employee.

Effective Date of Dependent Coverage

Subject to the Deferral Rule, a Dependent's coverage will take effect on the day that the Eligibility Requirement is met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

Deferral Rule

If a Dependent, other than a newborn child, is a patient in a Hospital or other Medical Care Facility or confined at home on the date coverage would otherwise become effective, coverage will be deferred until the day following the date the Dependent is discharged from the facility or home confinement, is in good health and able to perform all of the normal activities of a person of the same age and sex.

TERMINATION OF COVERAGE

When Employee Coverage Terminates

Employee coverage will terminate on the earliest of these dates:

- (1) The date the Plan is terminated.
- (2) The date on which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of employment of the covered Employee. (See the COBRA Continuation Option.)
- (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.

Continuation During Periods of Medical Disability or Leave of Absence

A person may remain eligible for a limited time if active, full-time work ceases due to disability or leave of absence. This continuance will end as follows:

For Employee medical leave only: the end of the 12 calendar month period that next follows the month in which the person last worked as an Active Employee. Employees on medical leave are required to pay the same contributions as Active Employees during the first three months of the leave. No contributions are required from the Employee during the fourth through the twelve months.

For leave of absence only: the end of the 12 calendar month period that next follows the month in which the person last worked as an Active Employee. Employees on an approved leave of absence are required to pay the same contributions as Active Employees for the duration of the leave.

A COBRA qualifying event will be deemed to occur on the first date of a leave of absence.

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, Broome County 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.

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, with the exception of an Employee returning to work directly from COBRA coverage.

Employees on Military Leave

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 18 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage in this Plan upon return from service. These rights apply only to covered Employees and their covered Dependents.

Plan exclusions may be imposed for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

When Dependent Coverage Terminates

A Dependent's coverage will terminate on the earliest of:

- (1) The date the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)
- (3) The date Dependent coverage is terminated under the Plan.
- (4) On the date that he or she ceases to be a Dependent as defined by the Plan. Dependent student coverage over age 19 will terminate on the first day of the month that follows the first date that he or she ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Option.)
- (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.

OPEN ENROLLMENT

An annual open enrollment period will be held once per year. The open enrollment period will be held during the month of November or at such other time selected at the discretion of the Plan Administrator. During the open enrollment period, covered Employees will be able to change their benefit enrollment decisions.

Benefit choices made during the open enrollment period will become effective January 1st and remain in effect until the next January 1st unless there is 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. Coverage waiting periods are waived during open enrollment.

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

SCHEDULE OF BENEFITS

BASIC, PREFERRED PROVIDER, AND MAJOR MEDICAL PLAN BENEFITS

This Plan provides Basic Benefits, Preferred Provider Benefits, and Major Medical Benefits. The Basic Benefits portion of the Plan pays certain covered expenses in full. The Preferred Provider Benefits are paid in full only if the services are provided by a Physician who participates with the Plan's preferred provider network. The Major Medical Benefits portion of the Plan supplements certain Basic Benefits and its reimbursements are paid after the Basic Benefits are exhausted.

Inpatient hospitalization and certain outpatient services are subject to Managed Care Review, please refer to page 24.

The Schedule of Benefits provides a brief summary of the Plan benefits which are fully described in this document.

BASIC BENEFITS

The following Basic Benefits are paid in full up to the Usual and Reasonable limit, subject to the specified maximums and limitations:

Inpatient care in an acute care general Hospital	(Subject to Managed Care Review)
Daily room and board limit	the daily average semi-private room rate
Ancillary Charges	paid in full
Intensive Care Unit charges	Hospital's ICU charge
Maximum number of days	365 per spell of illness
Inpatient Hospital care for Mental Disorders or Substance Abuse	(Subject to Managed Care Review)
Maximum number of days	120 days per Spell of Illness
Ambulance service per confinement maximum	\$50.00
Skilled Nursing Facility --	
Covered daily charge limit	Usual and Reasonable Charge for a semi-private room
Maximum number of days payable	365 days per spell of illness

Home Health Care --	(Subject to Managed Care Review)
Calendar Year maximum	40 visits
Hospice Care --	(Subject to Managed Care Review)
Hospital Outpatient Facility Charges	Usual and Reasonable Charges
Physical Therapy --	following surgery or inpatient hospitalization, paid in full up to the Usual and Reasonable rate. Physical Therapy in excess of 40 visits per Spell of Illness must be approved by the Managed Care Administrator.

Emergency Room

Treatment within	72 hours for accidental injury 12 hours for Medical Emergencies
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Outpatient Substance Abuse

(Subject to Managed Care Review)

Maximum number of visits	60 visits per calendar year
Maximum covered charge for intensive outpatient treatment provided in lieu of hospitalization	Usual and Reasonable Charges up to \$110 per day
Maximum covered charge for other outpatient treatment	Usual and Reasonable Charges

PREFERRED PROVIDER BENEFITS

Certain services that are provided by Physicians who participate in the Plan's preferred provider network are paid in full. These services are:

- ◆ Surgery and assistant surgery
- ◆ Anesthesia
- ◆ Diagnostic lab and x-ray
- ◆ Radiation and chemotherapy
- ◆ Consultations
- ◆ Maternity care
- ◆ In-Hospital Physician visits (including psychiatric care)
- ◆ Well child care (refer to covered services on page 16)

The above services are covered Preferred Provider Benefits only if the services are provided by a Physician who participates in the Plan's preferred provider network. If these services are provided by a Physician who does not participate in the preferred provider network, these expenses are considered under the Major Medical Coverage. Hospital charges are not covered as Preferred Provider Benefits.

MAJOR MEDICAL BENEFITS

The Major Medical Benefits portion of the Plan supplements certain Basic Benefits and its reimbursements are paid after the Basic Benefits are exhausted.

Deductible payable by Plan Participants, per Calendar Year

Per Covered Person and Family Unit Specified in Appendix A

The Major Medical Calendar Year deductible is waived for the following Covered Charges:

- ◆ Routine Physical Exams
- ◆ Well Child Care
- ◆ Second Surgical Opinions

Percentage Payable by the Plan, per Calendar Year

After satisfaction of the deductible, 80% of the first \$2,000 of covered charges incurred and 100% of the remainder each Calendar Year.

The charges for the following do not apply to the 100% benefit limit and are never paid at 100%.

- (1) deductible(s)
- (2) outpatient mental treatment charges
- (3) managed care penalties

Maximum Benefit Amounts

Lifetime and Calendar Year Specified in Appendix A

There are other maximums on individual benefits. These follow under Benefit Limits.

BENEFIT LIMITS

Hospital Daily Room and Board

Coverage

in excess of Basic Benefits, acute care only. Inpatient Mental Disorder treatment is covered under Basic Benefits only.

Payment rate	the average semi-private room rate
Ancillary Charges	Usual and Reasonable Charges

Intensive Care Unit

Daily limit	Hospital's ICU charge
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Ambulance Service

Per trip maximum	Usual and Reasonable Charge
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Surgery

Assistant surgeon benefits	Usual and Reasonable Charge
	20% of the Usual and Reasonable limit for the surgery
Secondary surgical procedures	50% of the Usual and Reasonable Charge

Physical Therapy

Physical Therapy expenses for up to 40 visits, if not covered under the Basic Benefits, may be covered under Major Medical. The therapy must be medically necessary and required to improve or restore functions within a reasonable and generally predictable period of time. Payment will not be made for therapy only to maintain your present condition.

Durable Medical Equipment

Percentage payable	same as for other illnesses
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Prosthetics/Orthotics

Percentage payable	same as for other illnesses
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Mental Disorders Treatment Limits

Inpatient physician care is covered up to the Usual and Reasonable Charge.

Outpatient care is payable at 80% up to a \$40 maximum payment per visit

Note: The above outpatient charges for Mental Disorders will not be counted in accumulating covered charges toward the 100% payment percentage of other charges, nor will outpatient charges be subject to the 100% payment.

Organ Transplant Coverage Limits

Organ and tissue transplants are covered except those which are classified as "Experimental and/or Investigational." A Covered Person's expenses as a donor are covered under this Plan only if the recipient is covered under this Plan.

Preventive Care

Routine Physical Exam Limits (Active Employees age 50 or over only)

Percentage payable	100%
Calendar Year maximum	\$50.00
Deductible	waived

Routine Well Child Care, if not provided by a Physician who is a participating preferred provider

Percentage payable	100% of the Preferred Provider allowance.
Deductible	waived

The Plan will cover the following well child visits for covered Dependents:

From birth to the child's second birthday	nine baby visits
From the child's second birthday to the seventh birthday	five child visits
Children between age seven and 19	includes an initial visit and additional visits, no more often than each 24 months

PRESCRIPTION DRUG BENEFITS

Pharmacy Option

Copayment, per prescription Specified in Appendix A

Mail Order Prescription Drug Option

Copayment, per prescription Specified in Appendix A

BASIC BENEFITS

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

BENEFIT PAYMENT

Benefits for Hospital Room and Board Charges

The Usual and Reasonable Charges for inpatient Hospital average semi-private room and board and Medically Necessary ancillary charges are paid in full up to 365 days per Spell of Illness. Charges for a private room are covered only if Medically Necessary. Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate. Days of inpatient skilled nursing care in a Skilled Nursing Facility or an acute care hospital are applied to the 365 day maximum per Spell of Illness at a rate of two Skilled Nursing Facility days equal to one acute care Hospital day.

Note: The Plan will pay the actual charges incurred (not to exceed 120% of the Diagnosis Related Group case based charge) by a Covered Person while confined as an admitted patient in an acute care general Hospital. The Plan will pay Hospital inpatient benefits to the participant. This Plan will not pay inpatient charges directly to an acute care general Hospital. Actual charges are reimbursed on this basis pursuant to New York State Public Health Law Section 2807-C.1.(c).

Benefits for Outpatient Charges

The Usual and Reasonable Charges for Hospital-billed outpatient medical services and supplies and diagnostic x-rays and lab tests are payable. Other Hospital-billed services and supplies payable are:

Benefits for Outpatient Diagnostic Services in the Outpatient Department of a Hospital

- (1) Radiology, ultrasound and nuclear medicine.
- (2) Laboratory and pathology.
- (3) ECG, EEG, and other diagnostic medical and physiological medical testing procedures.

Benefits for Outpatient Emergency Accident Care and Emergency Medical Care

- (1) Emergency care for the initial treatment of traumatic bodily injuries resulting from an accident. Treatment must be rendered within 72 hours of the accident.
- (2) Care for the initial treatment of a Medical Emergency within 12 hours of the onset of the Medical Emergency.
- (3) Emergency room charges, including Physician charges, not covered as Basic Benefits may be considered under the Major Medical Benefits portion of this Plan.

Facility charges for outpatient surgical care

Charges for Routine Nursery Care

Routine nursery care is room, board and other normal care for which a Hospital makes a charge. The Usual and Reasonable Charge made by the Hospital for routine nursery care provided while the mother is Hospital confined after birth will be considered as covered charges under the Plan. This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the child's birth and the child is an eligible dependent.

Benefits for Outpatient Therapy Services at a Hospital

- (1) Radiation therapy
- (2) Chemotherapy
- (3) Dialysis
- (4) Respiratory therapy

For the above listed outpatient services, a "special charge maximum" in the Schedule of Benefits will be paid for each Injury or surgical service. If there is no "special charge maximum" listed, 100% of the Usual and Reasonable Charge will be paid.

Benefits for Ambulance Charges

The Plan will pay up to \$50 for each trip in a medically equipped ambulance to the nearest Hospital that is capable of treating the condition and only when the ambulance and transfer is Medically Necessary. Air ambulance will be covered only if Medically Necessary and ground ambulance is not available. Additional coverage may be considered under the Major Medical provisions of this Plan.

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 Illness when Hospital or Skilled Nursing Facility confinement would otherwise be required and Home Health Care is a cost effective alternative to such confinement. 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.

The Plan covers the following Home Health Care services:

Part time or intermittent home nursing care by or under the supervision of a registered or professional nurse (R.N.)

Physical, occupational, or speech therapy; medical supplies, prescription medications, or laboratory services if prescribed by a Physician and approved by the Managed Care Administrator.

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. The Hospice Care Plan must be approved by the Managed Care Administrator. The Hospice organization must have an operating certificate issued by the New York State Department of Health or similar regulatory agency if Hospice care is provided outside of new York State. The per diem reimbursement for Hospice care must not exceed the cost of continued confinement in an acute care facility.

The Plan will pay for the following expenses under an approved Hospice Care Plan: laboratory and x-ray expenses, prescription drugs, covered medical supplies, and approved per diem professional fees for a Registered Nurse, Licensed Practical Nurse, home health aide, respiratory therapist, medical social worker, physical therapist, or occupational therapist. Payments under the Plan are limited to actual dates of service or per diem allowances not to exceed the Medicare per diem allowable charge.

Skilled Nursing Facility Care

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

- (a) The patient is confined as a bed patient in the facility;
- (b) Care in a Skilled Nursing Facility is medically necessary under criteria established by Medicare;
- (c) Skilled nursing Facility Care is a cost effective alternative to inpatient Hospital confinement; and,
- (d) 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.

Skilled Nursing Facility expenses or Hospital inpatient expenses while confined at a skilled nursing level of care are not covered by the Plan if you are eligible to receive primary benefits under Medicare, even if your Medicare skilled nursing care benefits are exhausted. Covered charges for a Covered Person's care in these facilities is limited to the covered daily charge limit shown in the Schedule of Benefits.

Outpatient Treatment of Substance Abuse

Outpatient Visits. The Plan will pay for outpatient visits if they are approved by the Managed Care Administrator. Each visit must consist of at least one of the following:

- (a) individual or group substance abuse counseling, or
- (b) diagnostic evaluations by a Physician. The Plan will not pay for visits that consist primarily of participation in programs of a social, recreational, vocational, or companionship nature.

Treatment Plan. The Physician must submit a treatment plan to the Managed Care Administrator within 10 days of the beginning of substance abuse treatment. No payment will be made for services provided after 10 days unless a treatment plan has been submitted to and approved by the Managed Care Administrator.

Number of Visits. The Plan will cover a maximum of 60 visits per calendar year. Up to 20 of the 60 visits may be used for family therapy. The number and frequency of the visits are subject to the approval of the Managed Care Administrator as part of the treatment plan.

Covered Providers. The Plan will only cover treatment by providers certified by the New York State Division of Alcoholism and Alcohol Abuse to provide outpatient substance abuse treatment.

Physical Therapy

Physical therapy following surgery or inpatient hospitalization is paid in full up to the Usual and Reasonable rate. Physical therapy in excess of 40 visits per Spell of Illness must be approved by the Managed Care Administrator.

The following criteria must be satisfied:

- ◆ The treatments are ordered by your Physician.
- ◆ The treatments must start within 6 months form your discharge from a Hospital or within 6 months from the date surgery was performed.
- ◆ The treatments are in connection with same illness for which you have previously been hospitalized or in connection with related surgery.
- ◆ The therapy must be to improve or restore functions within a reasonable and generally predictable period of time. Payment will not be made for therapy only to maintain your present condition.
- ◆ No payment will be made for physical therapy given after 365 days from the date you were discharged from a Hospital or the date of surgery.

MAJOR MEDICAL BENEFITS

Major Medical Benefits apply when covered charges are incurred by a Covered Person for care of an Injury or Illness and while the person is covered for these benefits under the Plan. The Major Medical Benefits portion of the Plan supplements the Basic Benefits and Preferred Provider Benefits, and its reimbursements are paid after the Basic Benefits are exhausted.

DEDUCTIBLE

Deductible

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.

Deductible Three Month Carryover

Covered expenses 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 combined expenses of an employee and his covered dependents that are credited toward individual Calendar Year deductibles equal the Family Unit deductible specified in Appendix A, 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 per Calendar Year will be required for them as a unit.

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 Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or the Benefit Limits of the Plan.

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 Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the "Benefit Limits" of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Acute Hospital Care.** Medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center are covered under Major Medical only after the Basic Benefits maximum of 365 days per Spell of Illness has been exhausted. Covered charges for room and board will be payable as shown in the Schedule of Benefits. Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate. Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.
- (2) **Physician Care.** The professional services of a Physician for surgical or medical services.
- (3) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:
 - (a) Anesthetic; oxygen; intravenous injections and solutions. Administration of these items is included.
 - (b) Diagnostic x-rays.
 - (c) Laboratory studies.
 - (d) Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.
 - (e) Rental of durable medical or surgical equipment if deemed Medically Necessary. These items may be bought rather than rented, but only if agreed to in advance by the Managed Care Administrator. Charges for the replacement of durable medical equipment are excluded under this Plan. In the case of purchased equipment, coverage is provided for repairs and necessary maintenance not provided for under a manufacturers warranty or purchase agreement during the expected useful life of the equipment.
 - (f) Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided, but in any event, no more than 50 miles from the place of pickup, unless the Managed Care Administrator finds a longer trip was Medically Necessary.
 - (g) Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

- (h)** The initial purchase, fitting, and repair of fitted prosthetic devices which replace body parts provided that the loss occurred while covered under the Plan. Replacement of prosthetic devices are covered only if Medically Necessary due to a change in physical condition. In the case of purchased equipment, coverage is provided for repairs and necessary maintenance not provided for under a manufacturers warranty or purchase agreement during the expected useful life of the equipment.
- (i)** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints or other appliances which are required for support for a weak or deformed part of the body as a result of a disabling congenital condition or an Injury or Illness that occurred while covered under the Plan. The orthotic must be Medically Necessary to ambulate, perform all the activities of daily living, and to prevent further injury. In the case of purchased equipment, coverage is provided for repairs and necessary maintenance not provided for under a manufacturers warranty or purchase agreement during the expected useful life of the equipment.
- (j)** 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 to improve a body function. Physical therapy to maintain a body function is not covered.
- (k)** Services of licensed chiropractors for the manual manipulation of the spine to correct a subluxation or other services if these services are prescribed by a Physician and approved by the Managed Care Administrator. Maintenance Chiropractic Care is not covered.
- (l)** Sterilization procedures. The reversal of sterilization procedures is excluded.
- (m)** Initial contact lenses required following cataract surgery or surgically implanted due to a disease.
- (n)** Covered charges for outpatient care and treatment of Mental Disorders will be limited as follows:

 - (1)** All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.
 - (2)** Physician's visits are limited to one treatment per day.
 - (3)** The Plan covers the services of Psychiatrists (M.D.), psychologists (Ph.D.) or a Registered and Certified Social Worker with at least 6 years of post degree experience.
- (o)** Blood and blood derivatives that are not donated or replaced, blood plasma and blood processing charges, only if blood products are not available free of charge.

- (p) Psychological testing, provided during an approved Hospital admission, not to exceed \$80 per hour for a maximum of eight (8) hours. Subsequent inpatient testing may be covered, not to exceed \$80 per hour for a maximum of six (6) hours. Inpatient psychological testing is covered only if provided for the diagnosis or treatment of a Mental Disorder and if such testing does not duplicate previous psychological tests. Outpatient psychological testing is covered under the Plan as outpatient treatment of Mental Disorders.

CARE FOR MOUTH, TEETH AND GUMS

Charges for the 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:

- (1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- (2) Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident and the accident must have occurred while the person was covered under the Plan.
- (3) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth when the Injuries occurred while covered under the Plan.
- (4) Excision of benign bony growths of the jaw and hard palate.
- (5) External incision and drainage of cellulitis.
- (6) Incision of sensory sinuses, salivary glands or ducts.
- (7) Reduction of dislocations or surgery of temporomandibular joints (TMJs).
- (8) Outpatient Hospital and anesthesiology charges for dental surgery performed in the outpatient department of a Hospital, if Medically Necessary.

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

PREVENTIVE CARE

Covered charges under Medical Benefits are payable for preventive care as described in the Schedule of Benefits.

Charges for Routine Physical Exams

Routine physical exams are limited to Active Employees who are age 50 and over.

Charges for Well Child Care

Well child care includes routine pediatric care and immunizations by a Physician that is not for an Injury or Illness.

Covered benefits include: Initial newborn Hospital examination; screening and early detection; health history; and routine physical examination.

The Plan covers immunizations for diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza Type B and hepatitis B. The immunization coverage includes vaccine, supplies and materials. Covered immunizations may be changed to be consistent with the current clinical standards set forth by the American Academy of Pediatrics.

ORGAN TRANSPLANT COVERAGE LIMITS

Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

- (1) The transplant must be performed to replace an organ or tissue of the Covered Person.
- (2) Charges for obtaining donor organs are covered charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
 - (a) evaluating the organ;
 - (b) removing the organ from the donor; and
 - (c) transportation of the organ from within the United States and Canada to the place where the transplant is to take place.

The Plan will always pay secondary to any other coverage for any charges incurred for obtaining donor organs.

- (3) Treatments, procedures, services, and/or supplies must be established clinical practice, and procedures or treatment methods approved as non-experimental and non-investigational as defined by this Plan.
- (4) The Hospital in which the procedure is performed must be Medicare approved for reimbursement of that particular transplant operation.

COVERAGE OF PREGNANCY

The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Illness. Abortion is covered under the Plan only if Medically necessary.

MANAGED CARE REVIEW

The Employee or family member must initiate the Managed Care Review process to receive certification of certain services subject to Managed Care Review. The Employee must contact the Managed Care Administrator at least one week in advance of a non-emergency Hospitalization or within 48 hours after an emergency Hospitalization.

Any reduced reimbursement due to failure to follow managed care procedures will not accrue toward the 100% maximum out-of-pocket payment.

Managed Care Administrator Phone Number

(800) 648-3400 or (607) 724-6520

The Managed Care Review process determines whether the Plan will pay for certain treatments. Treatment decisions are independent from payment decisions. The physician is responsible for determining whether treatment should be rendered regardless of whether the charges are totally or partially included in, or excluded from, coverage under this Plan.

PRE-ADMISSION REVIEW

Pre-admission review is a program designed to help Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses when a Hospital confinement is proposed.

The program consists of:

- (a) Precertification of coverage for all non-emergency Hospital admissions before medical services are provided;
- (b) Retrospective review of coverage for all emergency Hospital admissions;
- (c) Concurrent review, based on the admitting diagnosis, of the number of days of Hospital confinement requested by the attending Physician, and
- (d) Certification of the length of confinement and assistance with discharge planning.

The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a Hospital confinement is not certified, benefit payments under the Plan for all services related to the confinement will be reduced to 50% of the amount otherwise payable. In order to maximize Plan reimbursements, please read the following provisions carefully.

Precertification

Before a Covered Person enters the Hospital on a non-emergency basis, the Managed Care Administrator will, in conjunction with the attending Physician, certify that the care is covered. A non-emergency Hospitalization is one that can be scheduled in advance.

The pre-admission review program is set in motion by a telephone call from the Covered Person. Contact the Managed Care Administrator at...

Corporate Care Management, Inc.

(800) 648-3400 or (800) 252-4624

...**at least one week before** a non-emergency admission. Have the following information available:

- Your name and telephone number
- Patient name
- Plan name (Broome County Health Benefits Program)
- Employee name
- Employee Social Security Number
- Hours when you can be reached

Certain information may be needed by Corporate Care Management to determine coverage and make payment recommendations under the Plan's Managed Care Program. Participants should provide CCM with any facts needed in order to assure both proper coverage and payments.

If there is an **emergency** admission to the Hospital, the patient, patient's family member, Hospital or attending Physician must contact Corporate Care Management, Inc. **within 48 hours** of the first business day after the admission.

The Managed Care Administrator will determine the number of days of Hospital confinement authorized for payment. Failure to follow this procedure will reduce reimbursement received from the Plan.

Concurrent stay review, discharge planning. Concurrent stay review and discharge planning are parts of the utilization review program. The Managed Care Administrator will monitor the Covered Person's Hospital stay and coordinate with the attending Physician, Hospital and Covered Person to facilitate the scheduled release from the Hospital or approve coverage for an extension of the Hospital admission.

If the attending Physician feels that it is Medically Necessary for a Covered Person to stay in the Hospital for a greater length of time than has been precertified, the attending Physician must request the additional days.

Pre-Service Authorization

Coverage of specified outpatient services are also subject to authorization by the Managed Care Administrator. These services are:

- Magnetic resonance imaging (MRI)
- Chiropractic services
- Home health care
- Outpatient surgery
- Durable medical equipment rentals/purchases greater than \$500 annually

Failure to obtain authorization for these services may result in a 50% reduction in the benefit otherwise payable.

ALTERNATIVE BENEFITS

Broome County may provide alternative benefits in lieu of benefits otherwise provided under the Plan when it is reasonable and consistent with the provider's plan or care, medically sound, likely to produce cost savings and approved by the Employee. Alternative benefits may include procedures, services, courses of treatment, treatment setting and/or type of coverage under the Plan. Nothing contained herein shall require the Plan to provide a benefit which is experimental or otherwise uncovered, except as required by applicable law. Payment of benefits under these circumstances is based on the compliance by the Employee to rules and regulations of the Plan. The Plan may discontinue payment of alternative benefits should they no longer be medically necessary, no longer likely to produce cost savings, or desired by the Employee. Payment of benefits will then be payable under the normal terms of the Plan with prior notification to the Employee. There will be no penalty due the Employee if the alternative benefit is unsuccessful and/or necessitate additional benefit utilization. Further, Broome County acting through the Managed Care Administrator retains the right, in its sole discretion, to approve alternate benefits. Alternate benefits are approved on a case by case basis and alternative benefits do not change coverage under the Plan at any other time and has no bearing upon any future alternative benefits of coverage.

DEFINED TERMS

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

Active Employee is an Employee who

- (a) performs all of the duties of his or her job on a full-time or part-time basis;
- (b) normally works at least 18.75 hours per week; and
- (c) is in a class of employee eligible for coverage.

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.

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 (no more than 24 hours); 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.

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

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

Cosmetic Surgery means surgery to improve the appearance of the individual and which is not defined as Reconstructive Surgery. Some examples of cosmetic surgery include, but are not limited to: breast enlargement or reduction; liposuction; rhinoplasty; ear pinning; and facial lifts.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

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.

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

Employer is County of Broome.

Experimental and/or Investigational means treatments, procedures, drugs, services, and/or supplies unless they are, on the date the expense is incurred, an established standard of care as evidenced by one of the following:

- (a) approved for coverage by the Federal Government's Medicare program; or,
- (b) an abundance of scientific literature and well-designed clinical trials (ie: reports and/or articles in authoritative medical and scientific literature published in the United States); or,

In addition to the above, if a drug or device is used, it must also be approved by the FDA for this diagnosis, application or indication; or, be endorsed as a standard of care in a limited/restrictive context by a federal agency or a scientific organization. Drugs or substances labeled: "Caution - limited by Federal law to investigational use" are excluded.

Standard of care does not mean treatments, procedures, drugs, services and/or supplies for which:

- (a) scientific data may be considered promising, but at present are inconclusive regarding safety and efficacy;
- (b) no clear medical consensus is evident regarding its efficacy and/or safety;
- (c) there is no evidence that the majority of the medical community supports its use; or,
- (d) the research may be so limited that an appraisal of safety and efficacy cannot be made; or,
- (e) the application may have been shown to be unsafe or of no use as reported by current scientific literature and/or regulatory agencies; or,
- (f) a standard of care in other clinical applications and there is reasonably good data to support its use in the clinical application being reviewed even though the procedure, device, or drug is otherwise considered experimental/investigational.

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

Home Health Care Agency is an agency 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; 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 supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an agency 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 a bereavement period of up to one year provided that the family members are covered under the Plan.

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; 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 (RNs) and it is operated continuously with organized facilities for operative surgery on the premises.

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

Injury means an accidental physical harm 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.

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

Maintenance Chiropractic Care means chiropractic care received at a regular frequency (e.g. weekly, bi-monthly or less) for a chronic condition and related to the same Spell of Illness for which acute chiropractic care was received.

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

Medical Emergency means a sudden onset of a life threatening condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions. In addition, Medical Emergency includes a mental health or chemical dependency condition when the lack of medical treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Medically Necessary means medical treatment which is consistent with current accepted medical practice. Any confinement, operation, treatment or service must be approved as non-Experimental and non-Investigational as defined by this Plan. If services are not considered to be medically necessary and consistent with professionally recognized standards of care with respect to quality, frequency or duration, expenses related to those services will not be deemed "Medically Necessary". The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it medically necessary even though it is not specifically listed as an exclusion.

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 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 in the most recent Metropolitan Life Insurance Co. tables for a person of the same height, age and mobility as the Covered Person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care 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.

Period of Hospital Confinement is the period a person is confined as a bed patient in a Hospital. Hospital confinements due to the same or related causes will be considered the same Hospital confinement unless separated by the following:

- (1) For Active Employees - Separated by return to active full-time work for 90 days.
- (2) For Dependents and Retired Employees - Separated by at least 90 full days.

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 (as used in this Plan document) means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Licensed Professional Physical Therapist, Registered and Certified Social Worker with at least 6 years of post degree experience, Psychiatrist, Audiologist, Speech Language Pathologist, Midwife (if licensed and practicing under the supervision of a Doctor of Medicine).

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

Plan Year is the calendar year.

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

Prescription Drug means any of the following- a 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.

Reconstructive Surgery means surgery limited to improving/restoring bodily function or correcting deformity which has resulted in a functional, physical impairment due to (1) disease or trauma which first occurred when covered under this Plan, or (2) a congenital or developmental abnormality of a covered dependent child if the child was covered under this Plan at birth. It also covers surgery needed to restore a bodily function or correct a deformity of a part of the body that has been altered by injury, surgery or therapeutic processes that occurred while covered under this Plan.

Retired Employee is a former Active Employee who retired from Broome County and satisfies one of the following conditions:

- (1) If you were hired before March 1, 1979, you are eligible to continue coverage after retirement if you have completed five years of service with Broome County, and are qualified for retirement as a member of the New York State Retirement System.
- (2) If you were hired after March 1, 1979, you must have completed 10 years of service with Broome County and qualify for retirement as a member of the New York State Retirement System.

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 Illness. 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 retarded individuals, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare and accredited as a skilled nursing facility by the Joint Commission on Accreditation of Health Care Facilities.

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

Spell of Illness begins when:

- ◆ You are admitted to the hospital; or
- ◆ You are admitted to a skilled nursing facility; or
- ◆ You receive home health care.
- ◆ You receive care (e.g., chiropractic, physiotherapy) for your condition.

A Spell of Illness ends after 90 days when you have not:

- ◆ Been a patient in a hospital.
- ◆ Been a patient in a skilled nursing facility.
- ◆ Received home health care.
- ◆ Received care for your condition.

Spinal Manipulation/Chiropractic Care means skeletal adjustments or manipulation in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco, food, and ordinary caffeine-containing substances.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint problems 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 physical therapy, surgery, and any appliance that is medical rather than dental in nature.

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.

PLAN EXCLUSIONS

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

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

- (1) Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan.
- (2) Charges excluded by the Plan design as mentioned in this document.
- (3) Charges incurred for which the Plan has no legal obligation to pay.
- (4) Care and treatment of an Injury or Illness that is occupational -- that is, arises from work for wage or profit, including self-employment.
- (5) 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 Illness.
- (6) Care and treatment for which there would not have been a charge if no coverage had been in force.
- (7) 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.
- (8) Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (9) The part of an expense for care and treatment of an Injury or Illness that is in excess of the Usual and Reasonable Charge.
- (10) Charges for services received as a result of Injury or Illness caused by or contributed to by engaging in an illegal act or occupation, by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.
- (11) Any loss that is due to a declared or undeclared act of war.
- (12) Any loss due to an intentionally self-inflicted Injury, while sane or insane.
- (13) Professional services performed by a person who ordinarily resides in the Covered Person's home 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.

- (14) Care and treatment provided for cosmetic reasons. This exclusion will not apply if the care and treatment is related to reconstructive surgery or is for repair of damage from an accident that occurred while the person was covered under the Plan.

Reconstructive mammoplasty will be covered after Medically Necessary surgery, providing the reconstruction is performed within five years of the mastectomy.

- (15) Radial keratotomy or other eye surgery to correct nearsightedness or vision training. Also, 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).
- (16) Hearing aids and exams for their fitting.
- (17) 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, Illness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
- (18) Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (19) The following care, treatment or supplies for the feet: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; custom orthotics unless required within 90 days of surgery as part of the post-surgical treatment; Evaluation or treatment in connection with flat feet (pes planus), bunions, or unstable/unbalanced feet (e.g., plantar fasciitis, calcaneal heel spur syndrome, forefoot or rearfoot varus/valgus, hallux varus/valgus, talipes equino varus/valgus, metatarsus adductus, cavus foot type, metatarsus primus varus, hammertoe, etc.), except open cutting operations; and treatment of corns, calluses or toenails, unless needed in treatment of a metabolic or peripheral-vascular disease or infection.
- (20) Replacement of all orthotics and braces unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional and the brace is otherwise covered under the Plan.
- (21) Services for educational or vocational testing or training or services related to developmental delays.
- (22) Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (23) Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages, clothing, shoes, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

- (24) 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 illness. Medically Necessary charges for Morbid Obesity will be covered only if other medical conditions are complicated by the Morbid Obesity.
- (25) Care, services or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (26) Care and treatment for reversal of surgical sterilization.
- (27) Charges for procedures to induce a state of pregnancy. These include but are not limited to artificial insemination, in vitro fertilization, in vivo fertilization, and embryo transfer (GIFT).
- (28) Care and treatment for hair loss including hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician. The Plan will cover the expenses for one wig if hair loss is caused by the treatment of a medical condition.
- (29) Care and treatment for smoking cessation programs, including smoking deterrent patches.
- (30) Diagnostic testing for sleep disorders.
- (31) Exercise programs for treatment of any condition.
- (32) Services rendered in a government facility; or other services which are furnished in whole or in part under the laws of the United States for which no charge would be made if health plan coverage were not in effect. However, this exclusion will not apply to Veterans Administration or Defense Department hospitals except for service-related disability treatment.
- (33) Services to the extent covered by benefits to which an employee, retired employee or dependent:
 - ◆ Is entitled to under either Part A or Part B or Medicare.
 - ◆ Would have been entitled to under Part A or Part B of Medicare, if being eligible, the person failed to enroll for the coverage.
 - ◆ Would have been entitled to if the person had enrolled for Part B of Medicare, but failed to continue to make payment of the charges thereof.
- (34) Expenses of convalescent, custodial, or sanitarium-type care, or services in a place of rest, a place for the aged, a place for substance abuse treatment, or any nursing home, except (a) as otherwise specifically provided and (b) that expenses or services which are not rendered and billed by such institutions will be included if they otherwise qualify as Covered Expenses.

- (35) Services for which payment or reimbursement is received by or for the account of the individual as the result of legal action or settlement (other than from an insurance carrier under a separate policy of insurance issued to the individual).
- (36) Circumcision, unless Medically Necessary.
- (37) Expenses for non-prescription and prescription drugs, medicines and food supplements.
- (38) Charges for exclusions or penalties assessed by a primary Medical Plan, including but not limited to, failure to obtain precertification, second opinion, or failure to use participating Physicians or facilities.
- (39) Charges which are eligible for reimbursement under any motor vehicle liability insurance policy, including under any uninsured, underinsured, fault or no-fault policies, (including expenses which would have otherwise been payable under such a policy, but which are excluded from coverage under that policy due to conduct described under Section 5301(b) of the New York State Insurance Law).
- (40) Where Medicare is the primary payor, charges in excess of Medicare's limiting charge, when the Physician does not accept Medicare assignments.
- (41) Services for acupuncture.
- (42) Charges for Hospital room and board prior to the date of elective surgery, unless otherwise determined to be Medically Necessary.
- (43) Charges for travel and accommodations, whether or not recommended by a Physician, except for ambulance charges to the extent covered under this Plan.
- (44) Charges for any services that are not covered expenses under this Plan.

PRESCRIPTION DRUG BENEFITS

PHARMACY DRUG CHARGE

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

COPAYMENT

The copayment is applied to each covered pharmacy drug charge and is shown in the Schedule of Benefits. The copayment amount is not a covered charge under the Medical Plan. Any one prescription is limited to the greater of a 35-day supply or a 100-unit dose.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the copayment will be the ingredient cost and dispensing fee.

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, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

COPAYMENT

The copayment is applied to each covered mail order prescription charge and is shown in the Schedule of Benefits. It is not a covered charge under the Medical Plan. Any one prescription is limited to the greater of a 90-day supply or a 300-unit dose.

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) A charge excluded under Medical Plan Exclusions.
- (2) A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (3) Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (4) Immunization agents or biological sera.
- (5) A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (6) Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (7) Any charge for the administration of a covered Prescription Drug.
- (8) Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (9) 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.
- (10) A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (11) A charge for allergens.
- (12) A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than insulin).
- (13) A charge for contraceptive materials. Birth Control Pills are covered as of 1/01/2001.
- (14) Refilling of a prescription in excess of the number specified by the physician or dentist, or any refill dispensed after one year from the order of a physician or dentist.
- (15) Prescription drugs which may be properly received without charge under local, state or federal programs, including Worker's Compensation.
- (16) Drugs prescribed for use other than a use approved by the Federal Drug Administration.
- (17) Medication or any other prescription drug used for the treatment of photoaging. Coverage for such product for individuals age 26 or over is permitted through direct reimbursement and requires written documentation from the physician stating that the drug is not used for photoaging or wrinkles.

DISPENSING LIMITATIONS

As prescribed by a physician but not to exceed a 35 day supply.

Exceptions: The following drugs may be dispensed in maximum quantities of a 35 day supply or a 150 unit supply:

- ◆ Antiarthritic Drugs
- ◆ Anticholinergic and Parasympatholytic Agents
- ◆ Anticoagulants
- ◆ Anticonvulsants
- ◆ Antidiabetics
- ◆ Antifungal Agents
- ◆ Antihistamines
- ◆ Cardiac Drugs

HOW TO SUBMIT CLAIMS

Basic Benefits and Preferred Provider Benefits Claims are usually submitted directly to the Claim Administrator by the Hospital or Physician.

How to File Medical Claims

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 complete the provider's portion of the form or attach an itemized bill.
- (4) For Plan reimbursements, all claims must show:
 - ◆ Name of Plan
 - ◆ Group number of Plan
 - ◆ Employee's name
 - ◆ Employee's Social Security number
 - ◆ Name of patient
 - ◆ Name, address, telephone number, and tax identification 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:

RMSCO INC.
Attn: Group Health Claims
P.O. Box 6309
Syracuse, NY 13217-6309
877-300-7343

How to File Prescription Drug Claims

- If you receive your prescription drugs from a pharmacy which participates with Merck-Medco, you will pay up to \$10.00 (depending on labor agreement) for each prescription. The pharmacy will file a claim with Merck-Medco to obtain the balance of the charges.

- ◆ If you receive your prescription drugs from a non-participating pharmacy, or receive them from a participating pharmacy but fail to show your identification card, you must pay the full charge to the pharmacy, obtain a receipt and forward it with a completed claim form directly to Merck-Medco for reimbursement. Merck-Medco will reimburse you the same amount as it would have reimbursed a participating pharmacy; this amount may, or may not, cover the full charge. Be sure to obtain all information which is requested on the claim form. Incomplete claims cannot be processed.

If You Use the Mail Drug Option (MDO):

- ◆ You complete a MDO Enrollment/Order form once. Mail it together with the original prescription(s) written for up to a 90 day supply of medication.
- ◆ You may re-order a prescription by using a prescription order form or you may call a toll free number.
- ◆ The plan will pay the MDO directly for the cost of the prescription or refill.
- ◆ Prescriptions are delivered directly to your home postage paid.
- ◆ Claim forms are available in the Personnel Department.

Verification of Claim Information

The Claim Administrator and Managed Care Administrator have the right to request from hospitals, physicians, or other providers any information that is necessary for the proper handling of claims. This information is kept confidential.

FILING AN APPEAL

In the event that your claim has been denied in whole or in part, including the imposition of the deductible, and you do not agree with the denial, you may request that the Plan which issued the denial review its decision regarding your claim. Within 60 days of your receipt of written notification of the denial of your claim, you must file with Corporate Care a request that your claims be reviewed by the Plan. This request may be filed with the Plan by means of a written request. This request must identify the subscriber and the decision which is being reviewed, and must also explain the reason the subscriber does not agree with the denial of benefits.

You may designate a representative to act on your behalf in the review procedure. To designate a representative, you must provide a written statement specifying the name of the representative, the claim number or denial notice number, and the designation must be signed and dated. A written designation of a representative is necessary to protect against disclosure of information regarding the claim except to your authorized representative. Upon receipt of the request for review of the claim, you or your authorized representative have the right to:

- (a) Review documents pertinent to the claim under review at the Plan office during regular business hours. To avoid unnecessary delay for you or your representative, it is recommended that you provide at least three days notice to the Plan office of your desire to review documents pertinent to the claim under review.
- (b) Submit issues and comments in writing, and any additional information pertinent to the claim under review.

You or your authorized representative may review pertinent documents or submit written issues or comments or submit any additional pertinent information within 50 days after the Plan received your request for review. This procedure will allow the Plan to consider any comments or additional information which has been submitted so that a full and fair review of the claim may be obtained. The Plan Administrator may extend the 60-day period within which a written decision must be rendered, but in order to do so, the Plan Administrator must furnish you with a written extension notice prior the expiration of the initial 60-day period. The Plan Administrator will send you a written decision within 60 days after the Plan receives your request for review or within 120 days if the Plan extends the 60-day period. The written decision will contain the reasons for the decision and references to the pertinent contract provisions upon which the decision is based. If the written decision on review is not furnished to you within the appropriate time period (60 days or 120 days if an extension notice was sent), the claim is considered as denied until a written decision is made.

WHEN CLAIMS SHOULD BE FILED

Claims must be filed with the Claims Administrator within 90 days after the end of the calendar year in which the medical expenses were incurred. Claims filed later than that date will be declined.

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.

Benefit Plan

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

- (1) Group 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 Medicare.
- (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) plans. This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Also, when an HMO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO 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.

Automobile Limitations

When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered secondary 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 by these rules up to the allowable charge.
 - (a) The benefit plan that covers the patient as an Employee or member will be considered before a benefit plan that covers the patient as a Dependent.
 - (b) 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.

If the other benefit plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other benefit plan will determine order of benefits.
 - (c) 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.
- (d) 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.
- (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.

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.

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 for which benefits are paid by the Plan. The Injuries may be caused by the act or omission of another person. If so, the Covered Person may have a claim against that other person for payment of the medical or dental charges. The Plan will be subrogated to all rights the Covered Person may have against that other person.

The Covered Person must:

- (1) assign to the Plan his or her rights to recovery when this provision applies; and
- (2) repay to the Plan out of the recovery made from the other person or the other person's insurer.

Amount Subject to Subrogation or Refund

Only the amount recovered for medical or dental charges will be subject to subrogation or refund. In no case will the amount subject to subrogation or refund. In no case will the amount of medical or dental benefits paid for the Injury or Illness under the Plan.

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 right of subrogation. In addition, the Covered Person will do nothing else to prejudice the right of the Plan to subrogate.

Defined Terms

"Recovery" means monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries.

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

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

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, homeowner's plan, renter's plan or any liability plan.

COBRA CONTINUATION OPTIONS

Federal law gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost (plus a reasonable administration fee) must be paid by the continuing person. Coverage will end if the covered individual fails to make timely payment of contributions or premiums (within a maximum of 30 days). This law is referred to as "COBRA", which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. Generally, COBRA applies to employers with 20 or more full and/or part-time employees. Employees should check with their Employers to see if COBRA applies to them.

BENEFITS AFFECTED BY COBRA

There are two categories of benefits that may be continued under COBRA.

- (1) "Core benefits" are Medical Benefits. Any COBRA continuance option must include core benefits for which the person was covered just prior to the COBRA "qualifying event" (an event which qualifies a person for continued coverage under COBRA).
- (2) "Non-core benefits" include Dental Benefits, Vision Care Benefits and Flexible Spending Accounts under Section 125 (Cafeteria-type) plans.

If the "qualified beneficiary" (a person eligible for COBRA continuance) was covered by these non-core benefits prior to termination, the individual may, but is not required to, continue them under COBRA. Which non-core benefits, if any, are to be continued will be indicated by the qualified beneficiary at the time of COBRA enrollment.

Life insurance, accidental death and dismemberment benefits and weekly income are not considered for continuance under COBRA.

Maximum Time Periods

Continuation will be available for a qualified beneficiary up to the maximum time period shown in item (1), (2) or (3) below. Combined qualifying events will not continue a beneficiary's coverage for more than 36 months beyond the date of the original qualifying event, or when the qualifying event is "entitlement to Medicare", the 36 month continuation period is measured from the date of Medicare entitlement.

- (1) Up to 18 months for an Employee and his covered Dependent(s) when coverage terminates due to reduction of hours worked, or termination of employment for reasons other than gross misconduct.

Note: An individual who is disabled on the date of the qualifying event may have COBRA coverage extended (and an extra fee charged) from 18 months to 29 months provided that-

- (a) the individual is determined as being disabled for Social Security purposes on the date of the qualifying event; and

- (b) the individual notifies the Plan Administrator within 60 days of the qualifying event or Social Security Administration's determination of disability.
- (2) Up to 36 months for:
 - (a) a covered child who ceases to be an eligible Dependent;
 - (b) a covered Dependent of a deceased Employee;
 - (c) a former covered Spouse whose coverage ceases due to divorce or legal separation or
 - (d) a covered Dependent when the Employee's coverage ceases due to eligibility for Medicare.
- (3) There is a special continuation period for Retired Employees and their Dependents when declares bankruptcy under Title 1 of the United States Code and the Retired Employees and their Dependents lose substantial coverage within one year before or after the date that the bankruptcy proceedings commenced. Coverage will be continued for each person until the date of that person's death. However, the surviving Spouse or children of a deceased Retired Employee, may continue coverage for up to a maximum of 36 months following the Retired Employee's death. For this item 3, coverage does not terminate when the person becomes eligible for Medicare.

Continued coverage may also cease before the end of the maximum period on the earliest of:

- (1) The date that ceases to provide a group health plan to any Employee; or
- (2) The date that the qualified beneficiary first becomes, after the date of election, (a) covered under any other group health plan (as an Employee or otherwise), or (b) entitled to benefits under Medicare (except as stated in item 3 above). However, a qualified beneficiary who becomes covered under a group health plan which has a pre-existing conditions limit must be allowed to continue COBRA coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less.

Notice Requirements

When coverage terminates due to an Employee's death, termination or eligibility for Medicare, the qualified beneficiary has 30 days in which to notify the Plan Administrator of the qualifying event.

When coverage terminates due to divorce or change of Dependent status, the qualified beneficiary has 60 days from the qualifying event in which to notify the Plan Administrator that the qualifying event has occurred.

Complete instructions on how to elect continuation will be provided by the Plan Administrator within 14 days of receiving notice of the qualifying event. Covered Persons then have 60 days in which to elect continuation. The 60 day period is measured from the later of the date coverage terminates or the date the person receives notice of the right to continue. If continuation is not elected in that 60 day period, then the right to elect continuation ceases.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR

Broome County Health Plan is the benefit plan of County of Broome, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by County of Broome to be Plan Administrator. If the Plan Administrator resigns, dies or is otherwise removed from the position, the County of Broome 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 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.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To decide disputes which may arise relative to a Plan Participant's rights.
- (3) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (4) To appoint a Claims Administrator to pay claims.
- (5) To establish and communicate procedures to determine whether a medical child support order is qualified.

PLAN ADMINISTRATOR 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, Retiree, and Dependent Coverage:

Funding is derived from the funds of Broome County and contributions made by the covered Employees and Retirees.

The level of any Employee contributions will be set by the Plan Administrator, subject to any applicable collective bargaining agreements. 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 Broome County through the Claims Administrator.

THE TRUST AGREEMENT

If this Plan is established under a Trust agreement, that agreement is made a part of the Plan. A copy of the appropriate agreement is available for examination by Employees and their Dependent(s) at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee, Retiree or Dependent:

- (1) A copy of the Trust agreement.
- (2) A complete list of employers and employee organizations sponsoring the Plan.

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.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded welfare plan and the administration is provided through a third party Claims Administrator.

PLAN NAME

Broome County Health Plan

PLAN EFFECTIVE DATE

January 1, 1981

PLAN YEAR ENDS

December 31st

EMPLOYER INFORMATION

County of Broome
Risk and Insurance Department
Broome County Office Building, P.O. Box 5000
Binghamton, New York 13902
(607) 778-2402

PLAN ADMINISTRATOR

Risk Manager
County of Broome
Risk and Insurance Department
Broome County Office Building, P.O. Box 1766
Binghamton, New York 13902
(607) 778-2402

CLAIMS ADMINISTRATOR

RMSCO INC.
P O Box 6309
Syracuse, NY, 13217-6309

MANAGED CARE ADMINISTRATOR

Corporate Care Management, Inc.
1 Kattelville Road
Binghamton, New York 13901
(607) 648-3400
or
(800) 541-7403

BY THIS AGREEMENT, Broome County Health Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for County of Broome on or as of the day and year first below written.

County of Broome

Date

Witness

Date

