THIS SUMMARY PLAN DOCUMENT IS UNION SPECIFIC
AND MAY NOT APPLY TO ALL EMPLOYEES

OnPoint Program
Summary Plan Description
Health Benefits

As of the date listed below, this Summary Plan Booklet is not applicable to Onondaga County Employees classified under the DSBA and OCSPA unions and employees who are sworn Corrections Officers.

May 15, 2007

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Summary Plan Introduction

The effective date of the OnPoint Program is January 1, 1998.

This document is a Summary Plan Description of your Health Benefits. It is designed to give you a general outline of the Plan provisions and to help you understand the details of the Plan. You should read this document carefully to become familiar with the benefits you can expect to receive as a participant in the OnPoint plan. This document replaces any booklets or other documents you may have previously received. Please keep this booklet in a convenient place for future use as a reference.

The plan described in this booklet is subject to the provisions and limitations of the **Plan Document**. In any event where a question may arise as to a claim for benefits, the Plan Administrator, Claims Administrator or other individuals associated with the Plan will be guided solely by the **Plan Document**.

A copy of the **Plan Document** is on file in the Department of Finance, Division of Risk Management and in the Administrative Offices of each department.

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May 15, 2007

ELIGIBILITY

All full time and certain part-time employees become eligible for benefits on the first day of the month following satisfaction of any applicable waiting period. Benefits are also made available to eligible dependents. An eligible dependent is your spouse, regardless of age. Your spouse is eligible for coverage unless:

- You and your spouse are divorced or have obtained an annulment,
- S/he is of the same sex, or
- S/he is considered a spouse by common law.

Your unmarried child under the age of 19 is eligible in the following situations:

- Any natural children or any legally adopted child,
- Any stepchild who lives in the employee's household or for whom the employee contributes and provides at least *50* percent to the support of that stepchild,
- Any other child supported by the employee and permanently living in the household of which the employee or his spouse is head, provided such support and residence commenced before the child reached age 19.

The criteria of support will be deemed to have been met if the employee contributes at least *50* percent to the support of the dependent, and that dependent qualifies as an exemption on the most recent income tax return filed by the employee.

In addition the Program will cover the following:

1. Any unmarried child 19 years of age or older who is incapable of self support by reason of physical or mental disability as determined by the County, and who became so incapable before reaching age 19,
2. Any unmarried full time student who is enrolled in and attending an accredited secondary school or college, and who is 19 years of age or older, but under 26 years of age, who receives at least one-half of his support from the employee, and who is not eligible for other employer health benefits.

To be considered full-time, a student must be enrolled in and taking a minimum of 12 credit hours at an institution at which he/she is enrolled in and attending.

In order to obtain benefits for incapacitated dependents or full time students, you will be required to document appropriate certification of this fact. * Failure to provide this information will result in that particular child being removed from the Onondaga County Health Benefit Plan until proof is provided supporting eligibility under the Benefit Plan.

* Student certification is required each semester.

PRE-TAX CONTRIBUTION PROGRAM

As a County employee, you will be required to make certain contributions toward the cost of your health insurance. You must decide whether you want your share of the premium to be deducted from you paycheck before taxes are withheld or after taxes are taken. Making your contributions on a pre-tax basis (contributions are made before taxes are withheld) effectively reduces your reportable income by the amount of your contributions. Therefore, you pay federal, state and FICA taxes based on a lower salary. Because the pre-tax contribution program reduces your social security taxes, it may also slightly reduce your social security benefit at retirement age. The reduction is minimal, however, and is more than offset by the tax savings made over the years.

ENROLLMENT, CHANGES AND UPDATES

Your coverage will begin when you have satisfied any waiting period as required, and are enrolled in the Plan. An employee will be enrolled when s/he has completed and signed an OnPoint Plan Enrollment Form and an Onondaga County enrollment form and has delivered the form to Onondaga County as required.

If you are a new employee, you have 31 days from the date of hire to enroll for coverage. If you do not complete an enrollment form within 31 days after you become eligible for benefits, your benefits will not become effective until the first day of the month after a 90 day waiting period.

If a change occurs in your family status because of marriage, birth of a child, divorce, or death, contact the Employee Benefits Division, or, if you are employed at Onondaga Community College, contact the Office of Human Resources. This must be done within 31 days of the date of change. If you are not enrolled in the Pre-Tax program, failure to do so during this period will mean the new benefits will not become effective until the first day of the third month following your request to change your family status.

If you are enrolled in the Pre-Tax program, and changes in family status are not reported during the stated timeframe, application for these changes can only be made during the annual open enrollment period.

Failure to notify the County of changes in your family status which would cause a dependent to lose coverage, within a 30 day period, forfeits your right of continuation of benefits by the County under the COBRA law as explained under the COBRA section of your benefits booklet. In the case of a dependent that ceases to be eligible, you will be responsible for reimbursement of benefits paid after the date of the event that caused the dependent to lose eligibility.
Address changes must also be reported to Onondaga County.

No person may be eligible for benefits both as an employee and as a dependent or as a dependent of more than one employee.

The benefits described in this booklet will cease when your eligibility terminates or if you fail to make the required contributions toward the cost of your benefits.

There are certain Situations where you can remain eligible for benefits, even though your status changes from that of an active employee or your employment terminates. They are:

1. If you are on an approved leave of absence without pay, you may remain part of the group by making direct payments for benefits to the Employee Benefits Division.
2. A surviving spouse and dependents enrolled in the Program at the time of an employee or retiree's death will be eligible for benefits for 90 days from the date of death at no cost to the dependents. After that time, if the employee or retiree had ten or more years of service, the surviving spouse and dependents can maintain eligibility by completing an enrollment application and making direct premium payments.
3. If any employee dies and either an accidental death benefit is payable by a retirement or pension plan administered by New York State, or death benefits are payable under the Workers' Compensation Law of New York, all dependents may then continue benefits by making direct payments.
4. If an employee, enrolled under the OnPoint program, submits proof of total disability, has been disabled for at least 90 consecutive calendar days, and has made all required payments during time off the payroll, waiver of required contributions may then be allowed for a period of one year while the employee remains totally disabled. You will be considered Totally Disabled if, as a result of an illness or an accidental injury, you are unable to engage in any gainful occupation for which you are reasonably fitted by education, training, or experience, and are not able to perform work of any kind for wage of profit.
5. A retiree may remain part of the group by making required contribution and meeting the requirements of:
    a. At least age 55 and have 10 years of County service, OR
    b. Have at least 5 years of County service and is eligible to receive a retirement benefit through NYSERS at the time of separation, OR
    c. At least age 55 and have 5 years of County service and is eligible to receive a retirement benefit under TIAA-CREF.

The Benefit program for employees in the above situations may be modified periodically by the County.

OPEN ENROLLMENT PERIOD

Each year, employees will be given an opportunity to assess their health benefits package. This may be done during the open enrollment period. During this time, you will be allowed to decide benefit options offered by Onondaga County. Applications for changes between the Onondaga County Employee Benefit Plan (OnPoint) and available Health Maintenance Organizations must be made during this period. This open enrollment period also allows active employees who participate in the pretax contribution program to change their enrollment and coverage options.

COBRA

On April 7,1986, a new Federal law was enacted requiring that most employers sponsoring health and dental benefit programs offer employees and their families the opportunity for a temporary extension of health benefits (called “Continuation of Benefits") at applicable premium equivalents in certain circumstances where benefits under the Program would otherwise end.

If you are an employee enrolled in this Health Benefit Program, you have a right to choose this continuation of benefits if you lose your health benefits because of reduction in your hours of employment, or the termination of your employment (for reasons other than gross misconduct).

Your spouse, who is enrolled in the program, has the right to choose continuation of benefits for him/her if benefits are lost for any of the following reasons:

1. The death of the employee spouse
2. Termination of the spouse's employment for reasons other than gross misconduct, or reduction in the spouse's hours of employment which result in the loss of benefits.
3. Divorce or legal separation from the employee spouse

In the case of a dependent child who is enrolled in the Program, he or she has the right to continuation of benefits, if benefits are lost for any of the following reasons:

1. The death of the parent who is the employee under the Program
2. The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent’s hours of employment which causes that parent to lose benefits under this Program
3. Parents divorce or legal separation
4. The dependent child ceases to meet the definition of a dependent child under this program

It is your responsibility to inform the County of any situation, such as divorce, legal separation, or a child losing dependent status. When the County is notified within the proper timeframe that one of these events has happened, the County will in turn notify you that you have the right to choose continuation of benefits. You have 30 days from the date you would lose benefits because of one of the events described above, to inform the County that you want continuation of benefits. If you do not choose continuation of benefits, your health benefits will end. In order for your benefits to continue, you must pay the premium for this continuation. This cost will be equal to the full cost of the plan for active employees plus 2%.

The period for which benefits may be continued varies depending on the circumstances. In general, benefits may be continued for:

- 18 months for terminated employees and their family members, or employees working reduced hours and their family members
- 36 months for certain eligible dependents.

However, your continuation of benefits may be terminated for any of the following reasons:

1. Your employer no longer provides health benefits for any of its employees
2. You do not pay the premium on time for your continuation of benefits
3. You become eligible to be covered under another health benefit program
4. You become eligible for Medicare
5. You extended your coverage period due to your disability and there has been a final determination that you are no longer disabled.

COORDINATION OF BENEFITS

An employee, or eligible dependent covered under the Onondaga County Employees Benefit Plan, may also be eligible for medical services under another health benefit program.
The purpose of Coordination of Benefits is to prevent the payment of duplicate benefits, and assure that no more than the full amount of the bills be paid by both benefit plans together.
One plan is considered the **primary payor** and must pay its full benefits first. The other plan, the **secondary payor** will consider what has been paid by the primary payor and will make its payment up to the maximum allowed by that payor. In no case will the payments of the two payors total more than 100 percent of what was charged for medical services.
If you, or any of your dependents are enrolled in two or more health benefit programs, the following instructions should be followed when submitting claims:

1. If the claims are for a dependent spouse, submit claims to the dependent's health benefit program first. Any balance remaining can then be submitted for consideration through the Onondaga County Employees Benefit Plan, if you have family benefits.
2. If claims are for dependent children, and both parents have health benefits for which the children are enrolled, then the parent whose birthday occurs earlier in the calendar year is the primary payor, and claims should be submitted to that Program first.
3. When the parents are divorced or separated and claims are for dependent children the following applies:
    a. When a court decree has established financial responsibility for the children with one patent, claims must then be submitted to that parent's health benefit program first.
    b. Where no court decree is present, the parent who has custody of the children should then submit claims first to his/her health benefit program.

If none of the above apply, then the plan under which the parent has been enrolled the longest will be primary.

CLAIM INFORMATION

The Onondaga County Benefit Program (OnPoint) is a self insured benefit program. That means that the County pays for benefits covered under the program. Onondaga County has contracted with Excellus Blue Cross and Blue Shield of CNY to act as its Third Party Administrator to administer the program to its employees. For questions regarding a claim, call 1-800-796-6747.

All medical claims must be filed no later thin March 31 of the year following the year in which

the eligible service was received.

INFORMATION ABOUT THE ONPOINT PLAN ADMINISTERED BY EXCELLUS BLUE CROSS AND BLUE SHIELD OF CNY

Blue Cross and Blue Shield of CNY has contracted with a group of Physicians, Hospitals, and other ancillary Participating Providers who may be used by employees to provide most of the covered applicable services described in the Summary Plan Description. A list of Excellus Blue Cross and Blue Shield of CNY's Participating Providers can be found in the Directory of OnPoint Providers available in the County's Employee Benefits Division or at OCC's Office of Human Resources. Please note that the County of Onondaga does not contract directly with any medical provider nor do they promote one provider over another.

As an eligible member covered under this Plan, you are eligible to receive care by any Provider. When Participating Providers are used, the care you receive can be monitored to ensure that it is the most appropriate and cost-effective treatment required for your particular condition. Using a Participating Provider is voluntary on your part. However, if you use a Participating Provider, you will realize the following advantages:

- Participating Providers will file the claim for you,
- Participating Providers will always accept payment for covered services directly from Excellus Blue Cross and Blue Shield of CNY,
- You will not be billed for the balance of any Covered Expense in excess of the deductible, co-payment, and coinsurance amounts.

Your out-of-pocket costs for covered services provided by a Participating Provider normally will be less than your out-of-pocket costs for the same services provided by a Non Participating Provider. Participating Providers have an agreement with Excellus Blue Cross and Blue Shield of CNY to accept payment for covered services based on a predetermined fee schedule. Therefore, you will not be responsible for any charges which exceed the Participating Provider's fee schedule. When you use a non participating Provider, however, any difference between the Allowable Amount, which for purposes here will be referred to as Reasonable and Customary, and the Provider's actual charge will be your responsibility.

ONPOINT INFORMATION/ NETWORK STRUCTURE

There are separate payment levels under this Plan for Participating (i.e. Level One & Level Two) and Non participating (Level Three) Providers. The benefit amounts and limits with respect to covered services by both Participating and Non-participating providers are shown in the Benefit Summary Section.

ONPOINT NETWORK LEVELS EXPLAINED

OnPoint Network / Level One

Upon enrollment, eligible participants covered by the OnPoint Plan must choose a Primary Care

Physician (PCP) from a list of OnPoint Network/Level One PCP providers. In addition to your PCP, there are other OnPoint Network/Level One providers who may participate in coordinating your care.

Primary Care Physician. Your PCP is an OnPoint Network/Level One physician who is responsible for providing, coordinating, and managing all of your health care needs. If your PCP cannot render the suggested care, your PCP will refer you to another appropriate provider after obtaining any required pre admission review and prior approval for you.

Choice of a Primary Care Physician. You and each of your covered family members must choose a PCP upon enrollment. Before any benefit payment will be made under Level One for a covered service under the provisions of the OnPoint Plan, you must have selected a PCP. Each covered family member may select a different PCP from a list of Primary Care Physicians listed in your OnPoint Provider Directory. In addition to a PCP, women may also choose an OB/GYN from a list of Level One Providers provided by Blue Cross and Blue Shield of CNY.

Changing Primary Care Physicians. You may request a transfer from one Primary Care Physician to another. Any transfer will be effective upon completion of the processing of your change request. Upon completion of the processing, you will receive a new identification card indicating your new PCP.

If your Primary Care Physician terminates his or her agreement with the administrator of the OnPoint Plan, you will be notified for the purpose of selecting a new PCP.

Referrals by Your PCP. Effective March 1, 2007, the OnPoint Health Benefit Plan no longer requires a prior authorization referral from your primary care physician to a Level 1 Specialist or Specialty Provider. Services provided by OnPoint Level 1 Specialists or Specialty Providers are benefited, without penalty, at the Level 1 benefit payment. **If there is no OnPoint Network/Level One provider that specializes in the care or service you need, your PCP will seek prior approval from the administrator of the OnPoint Plan to refer you to an Extended Network/Level Two or Out-of-Network Level Three provider.** If the administrator of the OnPoint Plan gives prior approval for you to receive services from an Extended Network/Level Two or Out-of-Network/Level Three provider, you will receive OnPoint Network/Level One benefits. You will receive written notification of the prior approval or denial of the referral to another provider.

Please Note: The Plan still requires Pre-Certification for certain benefits. These services are outlined in this booklet. Please refer page 11 of this booklet more information regarding pre-certification requirements for services.

<u>**Extended Network / Level Two**</u>

If you choose not to use your PCP to provide or coordinate your care, benefits will still be provided for covered services under OnPoint; however, in most cases, your cost-sharing expenses will increase. To receive benefits under Extended Network/Level Two, you must receive covered services from an Extended Network/Level Two provider. Many OnPoint

Network/Level One providers are also Extended Network/Level Two providers. If your PCP provides or coordinates your health care, you will receive OnPoint Network/Level One benefits for covered services, with the least cost-sharing expenses to you. If you choose not to have your PCP provide or coordinate your care, benefits will be provided for covered services under Extended Network/Level Two, usually with increased cost-sharing expenses to you. See the Benefit Summary chart for a comparison of the benefits available for covered services.

An Extended Network/Level Two provider is one who has a contractual relationship and agrees to accept the allowed amount as payment in full after applicable deductible, co-payment, and/or coinsurance amounts are subtracted from the allowable amount. You will be responsible to the Extended Network/Level Two provider for the applicable deductible, co-payment, and/or coinsurance amounts. Benefit payment will be made directly to the Extended Network/Level Two provider.

Out-of-Network / Level Three

If you choose not to have your health care coordinated by your PCP, or do not choose an Extended Network/Level Two provider, your benefits will be provided under Out of Network/Level Three with the most cost-sharing expenses to you. See the Benefit Summary chart for a comparison of the benefit payments. An Out-of-Network/Level Three provider is one that does not have a contractual agreement with the administrator of the OnPoint Plan. An Out-of-Network/Level Three provider is not required to accept the allowable amount as payment-in-full, and the benefit payment may not equal the provider's charge. You will be responsible to the provider for all amounts not paid. The administrator of the OnPoint Plan will determine if payment will be made to you or the provider.

ONPOINT INFORMATION

How To Submit Claims For Benefits

The procedure to follow for submitting claims depends on whether you receive services from an OnPoint Network/Level One or Extended Network/Level Two Participating Provider, or an Out-of-Network/Level Three Non participating Provider.

Services from Excellus Blue Cross and Blue Shield of CNY Level I and Level 2 Participating Providers:

Both OnPoint Network/Level One and Extended Network/Level Two Participating Providers will forward all bills directly to Excellus Blue Cross and Blue Shield of CNY at the address indicated on your identification card. When you use a Participating Provider, be sure to show your identification card which bears the OnPoint/Blue Cross and Blue Shield of CNY logo. Excellus Blue Cross and Blue Shield of CNY will determine benefits for covered services in accordance with this Plan. Any payment will be made directly to the Provider. You will be responsible for any co-payments or coinsurance that is identified in this Summary Plan Description as your responsibility.

Services from Non Participating Providers:

If you receive a bill for medical services, send it to Excellus Blue Cross and Blue Shield of CNY

by using the claim form provided specifically for the OnPoint Plan. *Make copies of all documents you are submitting.* **Bills must be complete. Each bill must be an original and should show all the following:**

- Patient name
- Date(s) of service
- Charge for each service
- Diagnosis (reason for treatment)
- Type(s) of charge(s) (CPTA code and/or description of service(s) rendered)

PLEASE NOTE – THE FOLLOWING WILL NOT BE ACCEPTED:

- Canceled checks
- Cash register receipts
- Balance due bills (bills that show only the amount owed)

Should you need additional forms or have questions regarding claims, please feel free to contact the OnPoint Dedicated Services Unit. Claim forms are also available in the Office of Employee Benefits or at OCC's Office of Human Resources. Most payments will be made directly to the provider unless a paid in full receipt for the bill is received. <u>If you have any questions, please call or write</u>:

Blue Cross and Blue Shield of CNY
Attn: OnPoint Dedicated Service Unit
344 South Warren Street, P.O. Box 4809
Syracuse, NY 13221
Toll Free: (800) 796-6747

ONPOINT DEDUCTIBLE & OUT-OF-POCKET MAXIMUMS

Level Two / Level Three Deductible

All individual and family maximum annual deductible amounts that the covered person is required to pay for covered services rendered by Level Two and Level Three providers will be applied toward the deductible. Covered expenses that apply toward the deductible amounts are equal to the allowable amount, or charges, whichever is less.

The deductible amount applies separately to the covered employee and to each of his/her dependent(s), subject to any family maximum deductible that is listed in the Benefit Summary. The deductible amount must be satisfied once each calendar year. Additionally the plan allows for a carryover deductible provision. This means that if any part of the deductible amount has been satisfied during the last three months of a calendar year, the deductible amount for the next calendar year will be reduced by that amount.

If a covered person incurs eligible medical expenses through a Level Two or Level Three provider which exceed the deductible amount, the Plan will pay for this excess in accordance with the Coinsurance Provision set forth in the Benefit Summary.

The co-payments and coinsurance that the covered person pays for Level One services, and any amounts paid by the Plan for Level One services will not be applied toward reaching the deductible.

Level Two and Level Three Out-of-Pocket Maximum Amount

The benefit payment for Level Two and Level Three covered services that are subject to coinsurance will increase to 100% of the allowable amount, less any applicable deductible and/or co-payment for each covered person during the calendar year, after the covered person pays a total of the out-of-pocket maximum amount listed in the Benefit Summary coinsurance amounts for Level Two and/or Level Three covered services. The out-of-pocket maximum amount applies separately to the covered employee and to each of his/her dependent(s). A family can meet its family out-of-pocket maximum amount even if no individual meets the individual out-of-pocket maximum amount.

Only the coinsurance amounts that a covered person pays towards Level Two and Three covered services count towards the out-of-pocket maximum amount. Other cost sharing expenses that are paid by the covered person (e.g. deductibles, Level One co-payments and coinsurance, pre-certification penalties); and amounts that the covered person pays to a Level Three provider in excess of the allowable amount; will not count toward the individual or family out-of-pocket maximum amounts.

PRE-CERTIFICATION FOR CERTAIN BENEFITS

When a physician recommends that you or a family member be hospitalized, or when you receive other specified benefits, there are certain procedures that must be followed. You, a member of your family, a hospital staff member, or your doctor must notify Excellus Blue Cross and Blue Shield of CNY's OnPoint Dedicated Services Unit to pre-certify the admission. The OnPoint Dedicated Services Unit can be reached at (800) 796-6747. **The Plan pays hospital benefits minus $500 if the procedures for pre-certification are not followed.**

Failure to pre-certify Ambulatory (Outpatient) Surgery, Maternity Care (Including Birthing Facility/Midwife), Durable Medical Equipment and/or Prosthetic Device Purchases over $500, Orthotic Device Purchases over $250, Home Health Care, Hospice, Physical Therapy, Skilled Nursing Facility and certain machine testing will result in a $250 penalty. You will be responsible to pay this balance.

When you call the OnPoint Dedicated Services Unit, be prepared to provide:

- The patient's name and the employee's social security number;
- The treating physician's name, address, and phone number;
- The name of the hospital, and the anticipated admission date;
- Your employer's name, and group plan number.

This call must be made within at least seven (7) days prior to a planned Hospital Admission, and

all the other services listed above (i.e. ambulatory surgery, maternity care or the use of a Birthing Facility/Midwife, the purchase of Durable Medical Equipment or Prosthetic Devices over $500, the use of Home Health Care, Hospice, Physical Therapy, and Skilled Nursing Facility services). Please note that you must call for certification for emergency services within 48 hours of the time of an emergency admission, or the next normal working day. You must also call for certification upon confirmation from a doctor of your pregnancy, and again within 24 hours of the birth.

With hospital emergency room and urgent care center services, while you do not need a referral or pre-certification prior to services, if you are going to be admitted to the hospital after emergency room or urgent care, you are required to follow the pre-certification notification procedure.

Weekend Admission Exclusion

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

No Guarantee of Benefits

Completion of the pre-certification requirements as defined under the provisions of the OnPoint Plan is not a verification of benefits. The administrator of the OnPoint Plan will make a final benefit determination upon actual claim receipt.

THIS SECTION PROVIDES A SUMMARY OF THE ONPOINT BENEFITS. PLEASE BE SURE TO REFER TO ALL APPROPRIATE SECTIONS IN THIS SUMMARY PLAN DESCRIPTION FOR A COMPLETE DESCRIPTION OF THE BENEFITS PROVIDED BY THE ONPOINT PLAN.
Services identified as pediatric services for children ages 0 through age 15 are subject to a $12 co-payment

BENEFIT SUMMARY

BENEFIT FEATURES	ONPOINT NETWORK Level One	OUT-OF-NETWORK Level Two/Level Three
Allergy Treatment – Pediatric co-payment applies		
Office Visit		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$17 co-pay	20% of Allowable Amount and remaining balance
Injection Only		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and remaining balance

Ambulance (Including professional and volunteer)
The Plan pays the medically necessary, allowable amount for hospital professional ambulance or a volunteer professional ambulance that charges for its services. Coverage is limited to transportation to and from the hospital.

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$17 co-pay	20% of Allowable amount and remaining balance

Ambulatory Surgery (Pre-certification is Required)		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Anesthesia (In and Outpatient)		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Assistant Surgeon
The Plan pays for medically necessary professional services to render technical assistance to the operating surgeon when required in connection with the surgical procedure. No benefits are payable for surgical assistance rendered in hospitals when it is routinely available as a service provided by a hospital intern, resident or house officer. The reasonable customary assistant surgical allowance is determined by using 20% of the Surgeon's allowance.

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Bereavement Counseling (Benefit limited to the immediate family of Hospice patient and is limited to 5 visits)

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

BENEFIT FEATURES	ONPOINT NETWORK Level One	OUT-OF-NETWORK Level Two/Level Three

Chiropractic Care (Benefit limited to 30 visits per calendar year)
The Plan pays amount for medically necessary chiropractic services. This benefit is limited to acute care which is medically necessary and excludes any care which is custodial in nature or for maintenance treatment.

		After Deductible
The Plan Pays:	100 % of the Contracted Rate	50% of Allowable Amount
You Pay:	$17 co-pay	50% of any balance

Dental - *(Covers oral surgery for accidental injuries only)* **Pediatric co-payment applies**

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$17 co-pay	20% of any balance

Diabetic Supplies *(1ncluding educational and nutritional counseling. State mandated supplies covered under medical, other supplies covered wider* **Rx** *Plan)*
Benefits are available for a covered person with a diabetic condition. Benefits will only be provided for self **management education when a covered person** is initially **diagnosed** with diabetes, a physician **diagnoses** a significant change in your diabetic symptoms or condition that requires changes in your self management, or it is determined that reeducation is necessary.

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0 % of Contracted Rate	20% of Allowable Amount and any remaining balance

Diagnostic Laboratory

		After Deductible
The Plan Pays**:**	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0%	20% of Allowable Amount and any remaining balance

Diagnostic X-Ray Pre-certification may be required

		After Deductible
The Plan Pays	100% Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$17 co-pay	20% of Allowable Amount and any remaining balance

Dialysis

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Durable Medical Equipment (including Orthotic Devices)
(DME purchases over $500 and Orthotic purchases over $250 Pre-certification is Required).
The Plan pays for medically necessary, essential rental or purchase of durable medical equipment, or for repair in lieu of a replacement. Durable Medical Equipment is used to serve a medical purpose and is generally not useful to a person in the absence of illness, injury or disease. A physician must order the equipment before its rental or purchase. Benefits will only be provided for equipment that is determined to be least costly to adequately meet the needs of the condition Benefits will not be provided for' equipment that is primarily for the covered person's or their family's convenience. Examples of durable medical equipment are respirators, canes, crutches, walkers, and wheelchairs. Exclusions include, but not limited to, air conditioners, dehumidifiers, physical fitness equipment, hearing aids, eyeglasses & contact lenses (except as covered under the vision benefit), or articles of clothing, including shoes. The Plan will not cover any changes to your home, automobile or personal property. The plan will also cover certain medical supplies when medically necessary. **Please verify coverage prior to purchase**.

BENEFIT FEATURES	ONPOINT NETWORK Level One	OUT-OF-NETWORK Level Two/Level Three
		After Deductible
The Plan Pays:	80% of Contracted Rate	50% of Allowable Amount
You Pay:	20% of Contracted Rate	50% of Allowable Amount and any remaining balance
Out of Pocket Maximum:	$500 per individual $1,500 per family	

Gynecology – Pediatric co-payment applies
Routine exam including Pap Smear (limited to one per calendar year)

		After Deductible
Exam: The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$17 co-pay	20% of Allowable Amount and any remaining balance
Pap Smear:		After Deductible
The Plan Pays	100% of Contracted Rate	80% of Allowable Amount
You Pay	$0 co-pay	20% of Allowable amount and any remaining balance

Home Health Care (Pre-certification is Required)
Maximum benefit limited to 40 visits per calendar year. Four hours of care constitutes one home health care visit. Limit of one visit per day. Services must be prescribed by a physician and be medically necessary.

		After Deductible
The Plan Pays:	100% of Contracted rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Hospice Care *(Care for terminally ill; benefit limited to 210 days maximum per lifetime)*
Benefits are allowed for the confinement of a terminally ill patient as an inpatient in a Hospice facility and for home health care furnished to the terminally ill patient by the hospice provider, in the patient's home. There are no **benefits** allowed for charges incurred during a remission period or for services provided by yourself or a member of your family.

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Hospital Emergency Room Care
Notification to your PCP must be made within 48 hours of emergency room care- Care must he received within 24 hours of a life threatening injury or illness, and within 72 hours of an accidental injury (includes Urgent Care Center).

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$35 co-pay (Waived if admitted)	20% of Allowable Amount and and any remaining balance

Hospital Room & Board (Pre-certification Is Required)
Benefits are allowed for services and are paid up to the hospital's average semi-private room rate. Benefits will be provided to cover unlimited inpatient hospital days of care starting with the date of admission. <u>The plan does not pay room and board charges for weekend hospital admissions (Friday or Saturday) when treatment is not scheduled to begin until Monday. However, benefits will be available if your hospitalization begins on these days and you are receiving medically necessary treatment</u>

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

BENEFIT FEATURES	ONPOINT NETWORK Level One	OUT-OF-NETWORK Level Two/Level Three

Infertility
Includes diagnosis of infertility ONLY and does not include benefits for services to treat infertility such as, but not limited to artificial insemination and in-vitro fertilization.

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$17 co-pay	20% of Allowable Amount and remaining balance

Mammograms (Per physician recommendation, an/or routine as per schedule)

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Ages 35 and Over One mammogram every calendar year

Maternity -including prenatal, delivery, and post-partum care (Pre-certification is Required)

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$17 co-pay for initial visit only	20% of Allowable Amount and any remaining balance

Birthing Center and Midwife - including prenatal, delivery and post-partum care rendered within 24 hours after delivery
Benefits are allowed when the covered person is formally admitted to the birth center program. No benefit is paid for charges incurred for the services of a physician who renders technical assistance to the operating physician, or for those charges in connection with a pregnancy for which pregnancy related charges are not covered.

		After deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Medical Supplies
Benefits are allowed for medically necessary supplies when ordered by a physician.

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and remaining balance

Newborn Baby Care (Facility and Professional charges)
Benefits are allowed for hospital room and board, professional services and supplies, including circumcision, furnished by the hospital for a covered mother and/or newborn. Benefits for a newborn's illness or injury are only available if the newborn is a covered dependent under the Plan.

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

BENEFIT FEATURES	ONPOINT NETWORK Level One	OUT-OF-NETWORK Level Two/Level Three

Organ/Tissue Transplants
Benefits are allowed for the medically necessary organ or tissue procurement, services and supplies furnished by a facility provider, treatment and surgery by a professional provider, drug therapy to prevent rejection of the transplanted organ or tissue and surgical storage and transportation costs directly related to the procurement of an organ or tissue used in the transplant. **No benefits are payable for the purchase price of organs or tissue.**

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Physician Services – Pediatric Co-payment applies
INCLUDES:

Office / Home Visits

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$17 co-pay	20 % of Allowable Amount and any remaining balance

Diagnostic X-ray/Lab

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0%	20% of Allowable Amount and any remaining balance

Inpatient Hospital Visit – Benefit limited to one visit per day

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0%	20% of Allowable Amount and any remaining balance

Inpatient Consultation (Benefit limited to one visit per day)

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You pay:	$17 co-pay	20% of Allowable Amount and any remaining balance

Podiatry

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$17 co-pay	20 % of Allowable Amount and any remaining balance

Pre-Admission Testing – *(must be done* *within 7 days prior to admission)*

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0%	20% of Allowable Amount and any remaining balance

Prescription Drugs (The Retail Pharmacy and Mail Order Prescription benefits are administered through a separate Pharmacy Benefit Manager.)
All drugs and technologies newly approved by the U.S. Food and Drug Administration are subject to the review and approval of the Plan Administrator before they will be made available to enrollees.
Retail Pharmacy (limited to a 30 day supply)

You Pay:	$7 per generic prescription
You Pay:	The **greater of** 25% or $20 per Formulary (Preferred) brand name prescription; Maximum co-payment of $100 per prescription
You Pay:	The **greater of** 35% or $35 per Non-Formulary (Non-Preferred) brand name prescription; Maximum co-payment of $125 per prescription

Mail-Order Pharmacy (limited to a 90 day supply)

You Pay:	$7 per generic prescription
You Pay:	$20 per Formulary (Preferred) brand name prescription
You Pay:	$40 per Non-Formulary (Non-Preferred) brand name prescription

All FDA approved birth control medications and devices that require a prescription are covered under the prescription drug plan.

Qualifying expenses are those expenses in excess of the co-payment, which are:
- Necessary for the care and treatment of an illness;
- Prescribed in writing by an authorized physician;
- Reasonable and customary; and
- Not listed in the Exclusion section, below.

Prescription Drug Exclusions
The following limitations apply to the Prescription Drug Expense Benefit:
- Non-legend drugs, other than injectible insulin, or charges for the administration or injection of any drug are ineligible.
- Therapeutic devices or appliances (e.g., support garments, diaphragrns, and other non-medical substances) are ineligible.
- Any prescription that a person is entitled to receive without charge from any Worker's Compensation, or similar law, or municipal, state or federal program other than Medicaid is ineligible.
- Prescription drugs purchased prior to the effective date of this Plan are ineligible.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order is ineligible.
- Drugs labeled "Caution-Limited by Federal Law to Investigation Use," or experimental drugs, even though a charge is made to the individual are ineligible.
- Medication, which is to be taken by, or administered to, the Covered Person, in whole or part, while the Covered Person is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, or nursing home is ineligible
- Immunization agents, biological sera, blood or blood plasma are all ineligible.
- More than a 34 day supply or more than 100 unit doses, whichever is greater, when dispensed in any one prescription order is ineligible. However, under the mail order prescription program, many prescription orders for drugs may be dispensed in a supply sufficient to provide the prescribed dosage for up to 90 consecutive days without regard to quantity.
- Non-prescription vitamins, vitamin preparations (e.g. minerals, calcium, etc.), and nutritional supplements are ineligible.
- Anorectics (e.g. Redux. Fastin, Pondimin), are ineligible.
- Cosmetic agents are ineligible
- Smoking cessation agents are ineligible
- Dental products (Fluoride Prep & Dental Rinses) are ineligible
- Fertility Drugs are ineligible
- Impotence drugs are ineligible

BENEFIT FEATURES	ONPOINT NETWORK Level One	OUT-OF-NETWORK Level Two/Level Three

Preventive Care
Adult Physical Examinations (Benefit limited to once every calendar year)

The Plan Pays:	100% of Contracted Rate minus co-pay	Benefit Not Available
You Pay:	$17 co-pay	

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

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Prosthetic Devices (Over $500, Pre-certification is Required)
Benefits are allowed for the medically necessary initial purchase of prosthetic devices. It must be prescribed by a physician prior to its purchase. Prosthetic devices are used to replace functioning natural parts of the body. Such devices do not include for example, hearing aids, eyeglasses, cosmetic devices or wigs.

		After Deductible
The Plan Pays:	100 % of Contracted Rate	80 % of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Psychiatric Benefits – Pediatric co-payment applies
Inpatient: Limited to 60 days per calendar year including partial hospitalization

		After Deductible
The Plan Pays:	100% of Contracted Rate	50% of Allowable Amount
You Pay:	0% of Contracted Rate	50% of Allowable Amount and any remaining balance

Outpatient: Benefit limited to a 30 visit calendar maximum, with the total benefit not to exceed $100 per visit. Also, subject to a 120 visit lifetime maximum.

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	50 % of Allowable Amount
You Pay:	$17 co-pay	50% of Allowable Amount and any remaining balance

Second Surgical Opinion
A second surgical opinion is not mandatory. The Plan will pay the allowable amount for a second surgical opinion including charges for x-rays and laboratory tests. No benefits will be paid for duplicate testing

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$l7 co-pay	20% of Allowable Amount And any remaining balance

BENEFIT FEATURES	ONPOINT NETWORK Level One	OUT-OF-NETWORK Level Two/Level Three

Skilled Nursing Facility Care (Pre-certification is Required)

Benefits will not exceed the standard semi-private rate in the hospital from which the patient was transferred for room and board charges and other necessary services furnished while the patient is under continuous care of his/her doctor and requires 24 hour nursing care. (*Benefit limited to 100 days per calendar year maximum. Admission must be within 7days of a prior hospital stay)*

To be eligible for skilled nursing facility benefits, you must be a registered bed patient in a skilled nursing facility, the stay is for skilled care or treatment that is medically necessary and you would otherwise require care as a hospital inpatient if you were not in the skilled nursing facility. Benefits provided include nursing care, bed and board in a semi-private room, physical, occupational, respiratory or speech therapy, drugs, supplies and equipment, and other services generally provided by the skilled nursing facility.

		After Deductible
The Plan Pays:	100% of Contracted Pate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Substance Abuse (Alcoholism, Detox, Drug Addiction)

Inpatient: Limited to 28 days per confinement, two confinements per calendar year including partial hospitalization - Detox limited to 7 days maximum per confinement

		After Deductible
The Plan Pays:	100% of Contracted Rate	50% of Allowable Amount
You Pay:	0% of Contracted Rate	50% of Allowable Amount and any remaining balance

Outpatient: Benefit limited to 60 visits per calendar year maximum up to 20 visits may be used for family counseling.

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	50% of Allowable Amount
You Pay:	$17 co-pay	50% of Allowable Amount and any remaining balance

Surgery - Outpatient Facility (Ambulatory Surgery)
Pre-certification is Required

		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0%	20% of Allowable Amount and any remaining balance

Surgery - Physician's Charge
Inpatient and Outpatient

		After Deductible
The Plan Pays:	100 % of Contracted Rate	80% of Allowable Amount
You Pay:	0%	20% of Allowable Amount and any remaining balance

BENEFIT FEATURES	ONPOINT NETWORK Level One	OUT-OF-NETWORK Level Two/Level Three

Therapy including: **Cardiac Infusion Respiratory Chemo Oxygen Radiation Shock Diabetes – limited to mandated benefit**

Above services are all subject to the following:

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$17 co-pay	20% of Allowable Amount and any remaining balance

Therapy - Physical
Pre-certification is Required
Benefits are allowed for medically necessary home, office and hospital physical therapy visits by a licensed Physical Therapist. The therapy must be ordered by a physician or other health care professional licensed to order the therapy. The physical therapy must be for the diagnosis or treatment of the illness or injury.

Inpatient		After Deductible
The Plan Pays:	100% of Contracted Rate	80% of Allowable Amount
You Pay:	0% of Contracted Rate	20% of Allowable Amount and any remaining balance

Outpatient		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	50% of Allowable Amount
You Pay:	$17 co-pay	50% of Allowable Amount and any remaining balance

BENEFIT FEATURES	ONPOINT NETWORK Level One	OUT-OF-NETWORK Level Two/Level Three

Vision Plan Benefit
The Vision benefits are administered through Davis Vision. There are no out of-network vision benefits available under the Plan for either routine vision examinations or hardware. Once every 12 months, each covered person can utilize the vision benefit. The benefits are as follows:

- **A comprehensive eye examination from either an OnPoint or Davis Vision provider**
- **A complete pair or eyeglasses, or**
- **Contact lenses (in lieu of eyeglasses)**

Exam	100% of Contracted Rate less $17 co-pay at OnPoint providers **or** 100% of Contracted Rate at Davis Vision Providers	No Benefit Available
Hardware	100% of Contracted Rate less $17 co-pay	

- Eyeglass frames from the uniform selection in each Providers office (Premier Selection
- Lenses include:
  - Single, Bi-Focal and Tri Focal
  - Lenses (glass or plastic)
  - Oversized Lenses
  - Fashion & Gradient Tinting of Plastic Lenses
  - Glass - Gray #3 Prescription
  - Sunglasses
  - Scratch Coating
  - Polycarbonate Lenses
  - Blended Segment Bifocals

Optional additional services may be selected at the time eyeglasses are ordered. Designated co-payments are included in the Plan Document.

Contacts (Soft, Standard Daily Wear) or the initial supply of planned replacement/disposable lenses and medically necessary contact lenses

100% of Contracted Rate less $17 co-pay	No Benefit Available

Contacts (Non–plan contact lenses)

$100 member allowance	No Benefit Available

BENEFIT FEATURES	ONPOINT NETWORK Level One	OUT-OF-NETWORK Level Two/Level Three

Urgent Care Center
Notification to your PCP must be made within 48 hours of the Urgent Care Center Visit. Care must be received within 24 hours of a life threatening injury or illness, and within 72 hours of an accidental injury.

		After Deductible
The Plan Pays:	100% of Contracted Rate minus co-pay	80% of Allowable Amount
You Pay:	$17 co-pay (Waived if admitted)	20% of Allowable Amount and any remaining balance

Deductible

Individual:	$0	$250
Family:	$0	$750

Out of-Pocket Maximum:

Individual:	$1,500 plus deductible
Family:	$4,500 plus deductible

<u>Services which do not count toward fulfilling the deductible or out-of- pocket expenses include: pre-certification penalties, in-network co-payments, prescription drug co-payments, or any payments in excess of the Allowable Amount</u>

Lifetime Individual Maximum Benefit In-Network and Out of-Network Combined: $2,000,000

Calendar Year Individual Maximum Benefit - In Network and Out of Network Combined: $1,000,000

General Exclusions

1. OnPoint Network Level One benefit payments will not be made to any out of area network providers unless your care is provided or coordinated by your Primary Care Physician. However, there are exceptions. A covered person does not need a referral from their PCP for the following services:

   Hospital emergency room services;
   Inpatient mental care services (Pre-certification is Required);
   Inpatient alcohol and/or substance abuse treatment services (Pre-certification is Required);
   Outpatient alcohol and/or substance abuse treatment services;
   Outpatient mental care;
   Emergency care;
   Routine gynecological visits (including routine cervical screening);
   Chiropractic care; and
   Routine vision examinations.

2. Any expense for services not directly related to, or medically necessary for, the diagnosis or treatment of an illness or injury, unless specified in the Benefit Summary section under preventive care.

3. Any services if the covered patient was an inpatient in any institutional provider, or receiving home care or hospice benefits, on the day your coverage begins under the Plan. However, after the discharge from the facility or program, benefit payments for future covered services will be provided.

4. Any services or care that is eligible for coverage by mandatory no fault automobile insurance until the covered person has used up all the benefits under the mandatory no fault policy.

5. No benefit payment will be made that is payable under Medicare; or any other federal, state or local government program; except when required by state or federal law. When a covered person is eligible for a government program, benefits will be reduced by the amount the government program would have paid for the services. If a covered person is eligible for a government program, this reduction is made even if:

   The covered person fails to enroll;
   The covered person does not pay the charges for the program; or
   The covered person receives services at a hospital that cannot bill Medicare.

6. Any expenses caused by war (declared or undeclared) or any act of war.

7. Any expense incurred while on full-time active duty in the armed forces of any country, combination of countries, or international authority.

8. Any expense incurred in connection with any accidental bodily injury or illness arising out of; or in the course of any employment past or present), or which is compensatory under any Workers' Compensation or Occupational Disease Act or law.

9. Services received in a Veteran's Administration Hospital, a public health service hospital, or any facility operated by the U.S. government or any of its agencies are not covered, unless the benefit payment will be made for only service or care for non-service related conditions.

10. Dental Services: The Plan does not cover charges for doctor's services or x-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. This exclusion does not apply to charges made for treatment or removal of a malignant tumor, or for the following dental services received within 12 months after an accident: Treatment by a doctor, dentist, or dental surgeon for injuries to natural teeth including replacement of such teeth, and related x-rays.

11. Optical Services: The Plan does not cover eye surgery such as radial keratotomy when the primary purpose is to correct myopia (near sightedness), hyperopia (far sightedness), or astigmatism (blurring), orthoptics, visual therapy, or exams for the correction of vision and radial keratotomy eye surgery to improve visual acuity. (Basic vision benefits are available under the separate vision plan.)

12. Any expense for services rendered by you, your spouse, a parent, son or daughter, brother or sister of you or your Spouse, or by a member of your household.

13. Any expense which exceeds the Allowable Amount.

14. Any expense for care, services, and supplies not prescribed by a physician and/or treatment not rendered by a physician.

15. Any expense directly related to attempted suicide or an intentionally self-inflicted injury (whether sane or insane).

16. Any routine or elective expenses:

    Not mandated by law (shoes, orthotics, inserts, ankle pads, printed material, arch supports, elastic stockings, birth control, fluoride, vitamins, nutritional or dietary counseling, food supplements),
    -or-
    When no injury or illness is involved.

17. Custodial care

18. Any service or care for outpatient occupational or speech therapy, except when the covered person is receiving the therapy from a home health agency.

19. Any expense resulting from the attempt to commit a felony by the Covered Person.

20. Any service or care in connection with corns, calluses, flat feet, fallen arches, weak feet foot strain or chronic problems of the feet.

21. Expenses applied toward satisfaction of the deductible.

22. Any expenses for cosmetic surgery, except:

    The expenses incurred within two (2) years after an accident to repair or alleviate the damage from that accident.
    Surgery to restore bodily function or to correct deformity resulting from disease, trauma, congenital birth defects, or previous therapeutic processes.
    Reconstructive surgery following a mastectomy.

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

24. Expenses for actual or attempted impregnation or fertilization which involves either a Covered Person or a surrogate as a donor or a recipient; also expenses for in-vitro fertilization and artificial insemination are excluded.

25. Examinations, proper adjustment of or purchase of a hearing aid.

26. Any expense for career and pastoral counseling.

27. Services or supplies of an educational, experimental or investigatory nature.

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

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

This includes but is not limited to:

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

28. Charges for unnecessary services or supplies. A charge for services or supplies, including tests and check-up exams to the extent that they are not needed for the diagnosis of a sickness or injury, or the medical care of a diagnosed sickness or injury, unless specified in the Benefit Summary Section under Preventive Care.

29. Charges for elective sterilization procedures or the reversal of any sterilization procedure performed on any family member.

30. Expenses for sex transformation including hormones and any psychiatric treatment related to the transformation.

31. Services or supplies furnished by or at the direction of your employer, the company medical department, a mutual benefit association, a labor union, a health and wellness fund, an FIMO, or the U.S. Government, other than Medicaid, or any other government.

32. Services for weight reduction programs and gastric stapling for treatment of obesity.

33. In-vitro fertilization and artificial insemination.

34. Treatment for Temporomandibular Joint Dysfunction.

35. Hypnosis.

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

37. Lamaze (type) classes - child bearing classes.

38. For complications arising from any non-covered surgery or treatment.

39. Mail and/or shipping and handling expenses.

40. Travel expenses of a physician and a covered person.

41. Sale(s) tax.

42. Expense for or related to the removal of breast or other prosthetic implants that are not medically necessary.

43. Massage therapy or rolfing.

44. Adoption expenses.

45. Insertion and removal of Norplant implants.

46. Long term mental health or substance abuse residential treatment facilities, wilderness or camp programs.

47. Expenses for organ or tissue transplants, except for the following human-to-human transplant procedures:

    Cornea transplants
    Kidney transplants
    Heart transplants
    Heart/lung transplants, same donor
    Liver transplants
    Kidney/pancreas transplants, same donor
    Single/double lung transplants
    Autologous bone marrow transplants
    Allogeneic bone marrow transplants; and
    Other method(s) of stem cell support, by whatever name called.

48. Services or care that is furnished without charge, or that would have been furnished without charge if the recipient was not covered under the provisions of this Plan.

49. Any service or care when it is determined that the service or care is not expected to improve the condition of the recipient.

50. Any pharmacy services, clinical laboratory, x-ray or imaging services that were provided pursuant to a referral prohibited by New York State Public Health Law.

51. No benefit payment will be made for the elective termination of a pregnancy, including abortion.

52. The Plan does not pay benefits for services rendered for the following reasons:

    a. Academic or occupational problems,
    b. Failure to follow prescribed medical treatment or a defined treatment plan, or
    c. Borderline intellectual functioning or malingering

53. Charges for orthopic therapy (vision exercises)

54. Any service or care covered under the provisions of the OnPoint Plan, if billed by a person employed by an institutional provider except when required by state of federal law.

55. For prescription drugs that are covered under the Employer's Prescription Drug Plan, or co-payments.

56. Any pharmacy services, clinical laboratory, x-ray, or imaging services that were provided pursuant to a referral prohibited by New York State Public Health Law