SUMMARY PLAN DESCRIPTION
FOR

ONONDAGA COUNTY POINT OF SERVICE
HEALTH & WELLNESS PLAN (OnPoint)

Medical Claims Administrator:

POMCO GROUP

Prescription Drug Claims Administrator:

PROACT INC.
A PHARMACY BENEFITS MANAGEMENT COMPANY

Restatement effective: January 1, 2015

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INTRODUCTION

This document is a description of the Onondaga County Point of Service Health & Wellness Plan (the Plan); from here on named OnPoint. No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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

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

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

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

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

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

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

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

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

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

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

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is 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. If a word or phrase has a specific meaning, it starts with a capital letter and is either defined in the Defined Terms section or in the text of this document where it occurs.

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

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

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

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

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

The Plan believes that it is a "grandfathered" health plan under the Patient Protection and Affordable Care Act ("Health Care Reform"). As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of Health Care Reform that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections under Health Care Reform such as the elimination of Lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

The content in this section is not intended to constitute, or be validated as, the origin or basis for Plan eligibility requirements. The County's Employee Benefits Department can provide details concerning your specific eligibility requirements for Plan enrollment or the Employee handbook, as well as union contracts.

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

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

(1) is an Active Employee of the Employer. An Employee is considered Active if he or she normally meets the eligibility requirements of the Employer or by negotiated union contract agreement(s) and is an eligible individual of the Employer for that work.

(2) is a Retired Employee of the Employer under the age of 65 who had active coverage at time of retirement, and who:

(a) Tiers 4 and under: is at least 55 years of age with five years of service with Onondaga County, regardless of membership in the New York State Retirement System; or

(b) Tiers 5 and above: is at least 55 years of age with 10 years of service with Onondaga County, regardless of membership in the New York State Retirement System; or

(c) has five years of service with Onondaga County and is eligible to receive a retirement benefit through the New York State Retirement System at the time of separation regardless of age; or

(d) is 55 years of age, has five years of service with Onondaga County, and is eligible to receive a retirement benefit under the TIAA-CREF.

Please note: Some unions have a continuous service clause in their contracts. Please refer to your union contract for specific retirement criteria.

(3) is a Retired Employee who is 65 years of age or older and has two or more covered Dependents. Retirees who are 65 years of age or older with only one covered Dependent should meet with the Employee Benefits Department.

(4) is in a class eligible for coverage.

Persons not Eligible for Benefits. Persons in the following categories are not eligible for Plan enrollment or coverage under the Plan.

(1) Any terminated or laid-off Employee.

(2) Persons providing services to the Employer through a temporary agency or employer leasing organization.

(3) An independent contractor providing services to the Employer.

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

(1) **A covered Employee's Spouse.** The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state or other jurisdiction where the covered Employee lives or was married, and shall not include common law marriages. The term "Spouse" shall include partners of the same sex who were legally married under the laws of the state or other jurisdiction in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.

(2) **A covered Employee's Child(ren).** An Employee's "Child" includes his natural Child, stepchild, Legal Guardianship, adopted Child, or a child placed with a covered Employee in anticipation of adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the Child reaches the applicable limiting age, coverage will end on the last day of the Child's birthday month.

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

Any Child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

(3) **A covered Dependent Child who reaches the limiting age of 26 and is Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency.

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

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.

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; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

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

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

If both parents are Employees, their Children will be covered as Dependents of one parent, but not of both.

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

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

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

FUNDING

Cost of the Plan. The County shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage may include a payroll deduction authorization. This authorization should be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

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

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

Enrollment Requirements for Newborn Children. A newborn Child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan.

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

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

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 the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (Spouses) are covered under the Plan and the Employee covering any Dependent Children terminates coverage, the Dependent coverage may be continued

by the other covered Employee; no Waiting Period is required if coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their eligible Dependents who are not eligible to join the Plan during a Special Enrollment Period may join at any time after the applicable waiting period or during open enrollment.

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

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins 90 days after the enrollment form is received and approved.

OPEN ENROLLMENT

Eligible Employees who did not enroll themselves or their eligible Dependents when first eligible may apply during the annual open enrollment period specified by the Employer. Late enrollment can only be made during the Plan's open enrollment period except as described under the subsection entitled Special Enrollment Periods shown below. COBRA Continuation Coverage will be allowed if a Dependent Child or Spouse is terminated during Open Enrollment, even if the termination is not a COBRA qualifying event.

SPECIAL ENROLLMENT PERIODS

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

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

The Special Enrollment rules are described in more detail below.

The events described below may create a right to enroll in the Plan under a Special Enrollment Period. The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Losing Other Coverage May Create a Special Enrollment Right.** An Active Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all each of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) Either (i) the other coverage was under COBRA and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage and the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or Employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(e) For purposes of these rules, a loss of eligibility occurs if:

- **(i)** The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a Lifetime limit on all benefits.
- **(ii)** The Employee or Dependent has a loss of eligibility due to the Plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).
- **(iii)** The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the Plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
- **(iv)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
- **(v)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

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

(2) Acquiring a Newly Eligible Dependent May Create a Special Enrollment Right. If:

(a) The Employee is a participant under this Plan, and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

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

The Special Enrollment Period for newly eligible Dependents is a period of 31 days and

begins after the date of the marriage, birth, adoption or placement for adoption.

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

(a) in the case of marriage, not later than the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) **Eligibility Changes in Medicaid or State Child Health Insurance Programs May Create a Special Enrollment Right.** An Employee or Dependent who is eligible for, but not enrolled in this Plan, may also enroll in this Plan when.

(a) the Employee or Dependent loses eligibility under Medicaid or the state's Children's Health Insurance Program (CHIP), and the Employee requests coverage under this Plan within a Special Enrollment Period of 60 days after the date of termination of coverage; or

(b) the Employee or Dependent becomes eligible for premium assistance under Medicaid or the state's Children's Health Insurance Program (CHIP) to subsidize the cost of coverage in this Plan, and the Employee requests coverage under this Plan within a Special Enrollment Period of 60 days after eligibility for a premium assistance subsidy is determined.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. Management and Confidential Employees will be covered under this Plan as of the first day of the month following the month following the date that the Employee satisfies all of the following. Union Employees will be covered under this Plan 90 days from the first date of employment and satisfies all of the following.

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

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

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

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material

misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

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

(1) The date the Plan is terminated.

(2) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(4) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

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

For disability leave only: Employees Totally 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. Appropriate medical documentation must be submitted to the Employee Benefits Department to support Total Disability.

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

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

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

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

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. The Employee is required to pay any applicable contributions as billed; if there is nonpayment of contributions, COBRA will be offered.

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, to the extent permitted by applicable law.

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

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24-month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, the performance of uniformed service.

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

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

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See Survivor’s Coverage and Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of dependency status. In the case of divorce, coverage will end on the date of the court decree. The County has a right to recover any payments for ineligible Dependents. (See the Survivor’s Coverage and Continuation Coverage Rights under COBRA.)

(4) On the last day of the month that a Dependent Child ceases to be a Dependent as defined by the Plan. (See the Continuation Coverage Rights under COBRA.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Survivor's Coverage

When an Employee or Retired Employee dies, coverage for his/her Dependents who were covered at the time of the Employee's/Retiree's death shall continue for 90 days from the date of death at no cost to the Dependents.

The unmarried Spouse and Dependent Children (while eligible) of deceased Employees/Retirees with 10 or more years of County service may continue coverage under the Plan if the survivors pay the required contribution. No application of this continuation of coverage will be accepted more than 90 days after the death of the Employee or Retiree.

SCHEDULE OF BENEFITS

Verification of Eligibility 1.866.543.0277

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

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

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

The Plan is a plan which contains Network Provider Organizations.

PPO name: OnPoint Level One, MultiPlan/PHCS and POMCO
Telephone: 1.866.543.0277
Web: www.MyPOMCO.com (log on, click on “Find a Physician or a Hospital”)

This Plan has entered into an agreement with certain Hospitals, Physicians, and other health care Providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. The Plan agrees to reimburse the Provider directly for Covered Services.

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

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

Under the following circumstances, the In-Network benefit will be made for certain Out-of-Network services:

If services are performed at a Level One Hospital or facility, then all the services rendered at the Level Two and Level Three performing duties at that Hospital or facility will also be treated as Level One, subject to the Allowed Charge.

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

Coordination of Benefits. When services and supplies are rendered and billed by an In-Network or Out-of-Network Provider and this Plan is the secondary payer of benefits according to the Coordination of Benefits provision and Medicare Secondary Payer rules, In-Network benefits will apply. Copays usually do not apply.

Deductibles/Copayments Payable by Plan Participants. Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A Deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one Deductible amount per Plan and generally it must be paid before any money is paid by the Plan for any Covered Charges that apply to the Deductible as indicated in the Schedule

of Benefits. Each January 1st, a new Deductible amount is required. However, Covered Charges Incurred in, and applied toward the Deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year. Deductibles accrue toward the 100% maximum Out-of-Pocket payment.

A Copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services and other services will not have any Copayments. Copayments do not accrue toward the 100% maximum Out-of-Pocket payment.

Primary Care Physician (PCP) - A Covered Person may choose a Primary Care Physician (PCP) from the OnPoint Network.

Each covered Family Member may choose a PCP upon enrollment. Before any benefit payment can be made as a Level One covered service, a PCP should be selected. Each covered Family Member may choose a different PCP. Women may also choose an OB/GYN Physician from the OnPoint Network.

A Covered Person may transfer from one PCP to a different PCP. This transfer will be effective the date the request is received.

Level One, Level Two, Level Three Providers

(1) **A Level One Provider** is a Provider in the OnPoint Network.

(2) **A Level Two Provider** is a Provider that is in the POMCO or PHCS Multiplan network.

(3) **A Level Three Provider** is a Provider that is not in the OnPoint, POMCO or PHCS/ Multiplan Network. Covered services will be paid at the Level Three benefit. These Providers do not have contractual agreements with the Claims Administrator and are not required to accept payment in full. Covered Persons will be responsible to the Provider for all amounts not paid.

If there is not an OnPoint Provider available to provide Medically Necessary care, the Physician will contact the Claims Administrator for approval to receive services from a Level Two or Level Three Provider at the Level One benefit payment. Written notification will be sent if the request is approved.

Out-of-Area Exception. Level One Benefits will be available for covered services and supplies rendered by Level 2 and Level 3 Out-of-Network Providers if there is no Network Provider available to treat a Medical Emergency, as defined:

- when the Covered Person is traveling out of his or her home area including out of the country when the emergency services are rendered; or
- when the Covered Person lives outside of the 26 Network Counties and approval is obtained by the County.

COST MANAGEMENT SERVICES

Precertification or preauthorization does not guarantee benefits to you or your Provider and will not result in payment of benefits that would not otherwise be payable. It is a preliminary review based entirely on the limited information provided to POMCO Benefit Management Department at the time of the requested service authorization. All claims are subject to review to decide whether services are covered according to Plan limitations and exclusions in force at the time services are rendered.

Cost Management Services Phone Number

POMCO – 1.866.543.0277

Please refer to the Employee ID card for the Cost Management Services phone number.

This Cost Management program does not apply if your primary coverage is Medicare or another group health benefit plan.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least seven days (business days) in advance of services being rendered or within 48 hours after an emergency.

Any costs incurred because of reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum Out-of-Pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(1) Precertification of the Medical Necessity for the following non-Emergency Services before medical and/or surgical services are provided:

Home Health Care
Hospitalizations, except in observation settings
Rehabilitation Facility stays
Skilled Nursing Facility stays
Substance Use Disorder/Mental Disorder inpatient admissions, except in observation settings

Breast reduction surgery
Dialysis
Durable Medical Equipment and Prosthetic devices over $500
Eye lid surgery
Infusion (Intravenous) services (separate from home health care)
MRA (magnetic resonance angiography), except in ER/inpatient and observation settings
MRI (magnetic resonance imaging), multiple scans, except in ER/inpatient and observation settings
Orthotic devices over $250
PET scans, except in ER/inpatient and observation settings
Removal of excess abdominal skin and fatty tissue
Shock therapy
Thigh lift surgery
Transplants, including but not limited to organ and stem cell transplants
Varicose vein surgery

(2) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(3) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(4) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment 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 particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's How the Program Works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency inpatient basis or receives other medical services listed above, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card at least seven days (business days) before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Member ID number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48** hours of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by $500 for inpatient services and $250 for non-inpatient services.

Concurrent Review, Discharge Planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

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

CASE MANAGEMENT

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

deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

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

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

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

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

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

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

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

Summary of Benefits

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

Plan Features	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Level Three
Deductible per Calendar Year • **OnPoint** • **OnPoint MC** • **OnPoint DSBA**	Does not apply	$250 per individual $750 per family (three family members) Once the family Deductible has been met by any number of individuals, the Deductible is met for all	$250 per individual $750 per family (three family members) Once the family Deductible has been met by any number of individuals, the Deductible is met for all
Carry-over Individual Deductible	Does not apply	Covered Charges incurred in, and applied toward the Deductible in October, November, and December will be applied to the Deductible in the next Calendar Year as well as the current Calendar Year.	
Common Accident Deductible	Does not apply	$250 per family Cumulative for two or more covered family members injured in the same accident. Only expenses due to that accident and applied against the Plan Deductible count toward this limit. Expenses also count toward the Calendar Year Deductible.	
Network Copayment • **OnPoint** • **OnPoint DSBA**	$17 Copayment per Physician office $12 Copayment for pediatric services as defined in the Plan and incurred by Enrollees ages 0 thru 15.	Does not apply	Does not apply
• **OnPoint MC**	$20 Primary Care Physician Copayment per Physician office visit $40 Specialist Physician Copayment per Physician office visit	Does not apply	Does not apply
Benefit Copayment • **OnPoint** • **OnPoint DSBA**	Ambulance $17 Emergency Room $35 Urgent Care $17	Does not apply	Does not apply
• **OnPoint MC**	Ambulance $40 Emergency Room $35 Urgent Care $20	Does not apply	Does not apply

Plan Features	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Level Three
Durable Medical Equipment (DME) Out-of-Pocket (OOP) Limit	$500 per person $1,500 per family	$500 per person $1,500 per family	$500 per person $1,500 per family
	DME OOP Limit only applies to covered DME. The Limit is combined for all benefit Levels. This Limit also applies to the Medical OOP Limit listed below.		
Percentage Coinsurance	The Plan pays 100% of the allowable Network fee for most covered services and supplies.	The Plan pays 80% of the allowable Network fees for most covered services and supplies.	The Plan pays 80% of URC for most covered services and supplies.
Medical Out-of-Pocket (OOP) Limit Including Deductible, per Calendar Year • **OnPoint** • **OnPoint DSBA**	Does not apply	$1,500 per person $4,500 per family	$1,500 per person $4,500 per family
		Out-of-Pocket limit does not apply to: Precertification penalties, Network or Benefit Copayments, Prescription Drug Copayments or any payments in excess of the allowable amounts. Once the OOP limit is met, the remainder of the Covered Charges are payable at 100% of the Allowed Charges for the remainder of the Calendar Year.	
• **OnPoint MC**	$1,500 per person	$1,500 per person $4,500 per family	$1,500 per person $4,500 per family
	OOP limit does not apply to: Precertification penalties, Prescription Drug Copayments or any payments in excess of the allowable amounts. Once the OOP limit is met, the remainder of the Covered Charges are payable at 100% of the Allowed Charges for the remainder of the Calendar Year.	**OOP limit does not apply to:** Precertification penalties, Network or Benefit Copayments, Prescription Drug Copayments or any payments in excess of the allowable amounts. Once the OOP limit is met, the remainder of the Covered Charges are payable at 100% of the Allowed Charges for the remainder of the Calendar Year.	

Plan Features	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Level Three
Cost Management Services Program/ Pre-certification	This mandatory program requires a phone call before the Covered Person is admitted to a Hospital/facility or before an elective surgical procedure is scheduled to be performed in an inpatient setting. Please contact the POMCO Benefit Management Program toll-free at 1.866.543.0277. A benefit reduction of $500 will be applied for non-compliance with the inpatient pre-certification requirement and a benefit reduction of $250 will be applied for all other Medically Necessary services that are not compliant with the pre-certification requirement. Pre-certification is required for the following services: Home Health Care Hospitalizations, except in observation settings Rehabilitation Facility stays Skilled Nursing Facility stays Substance Use Disorder/Mental Disorder inpatient admissions, except in observation settings Breast reduction surgery Dialysis Durable Medical Equipment and Prosthetic devices over $500 Eye lid surgery Infusion (Intravenous) services (separate from home health care) MRA (magnetic resonance angiography), except in ER/inpatient and observation settings MRI (magnetic resonance imaging), multiple scans, except in ER/inpatient and observation settings Orthotic devices over $250 PET scans, except in ER/inpatient and observation settings Removal of excess abdominal skin and fatty tissue Shock Therapy Thigh lift surgery Transplants, including but not limited to organ and stem cell transplants Varicose vein surgery		

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.866.543.0277. See the section entitled Cost Management Services for details.

Service Type	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Benefits Level Three
Acupuncture	Not covered	Not covered	Not covered
Allergy Office	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Allergy Injections	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Allergy Serum	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Allergy Testing	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Ambulance	Benefit Copayment 100% of Allowed Charges	Benefit Copayment 100% of Allowed Charges	Benefit Copayment 100% of Provider charges
	Professional and volunteer ambulance and air ambulance are covered. Limited to transportation to and from the nearest hospital that can give the necessary care and treatment.		

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Service Type	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Benefits Level Three
Ambulatory Surgical Center, Freestanding	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Anesthesia	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Excludes services covered under the Infertility provisions of the Plan. Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions, for example: covered electroshock therapy.		
Biofeedback	Not covered	Not covered	Not covered
Blood and Blood Product Services	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Cardiac Rehabilitation			
• **Freestanding Facility**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient Hospital**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Physician Office**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Chemotherapy			
• **Freestanding Facility**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient Hospital**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Physician Office**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Chiropractic Care	Network Copayment then 100% of Allowed Charges	50% of Allowed Charges after Deductible	50% of Allowed Charges after Deductible
	Benefits are limited to total of 30 visits per Covered Person per Calendar Year combined In- and Out-of-Network. Maintenance Care is not covered.		
Consultation			
• **Disease Management**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Inpatient Consultation**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient/Office**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Second Surgical, Voluntary**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible

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Service Type	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Benefits Level Three
Dental Care, Limited	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	For medically necessary treatment for a fractured jaw and/or accidental Injury only to Sound Natural Teeth.		
Diabetic Education	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Diabetic Supplies/ Equipment	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Medically Necessary insulin pumps and glucometers are covered under the Prescription Drug Benefits. Syringes are covered under the Medical Supplies (home use) benefit or Prescription Drug Benefits. Additional diabetic supplies are covered under your Prescription Drug Benefits.		
Diagnostic Testing • **Independent/Free-standing Laboratory**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Laboratory**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient Hospital**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Professional Interpretation**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **X-ray**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Office**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	☎Except in ER/Inpatient or Observation settings. MRA, multiple MRI, PET scans. One copayment per date of service per Provider. There is not a Copayment for reading and interpretation. Benefits will not be provided for any Hospital charges for use of the emergency or outpatient room in connection with diagnostic services and radiology services. Excludes services covered under the Preventive Care and Infertility provisions of the Plan.		
Dialysis ☎ • **Freestanding Facility**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient Hospital**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Physician Office**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Durable Medical Equipment ☎ over $500	80% of Allowed Charges	50% of Allowed Charges after Deductible	50% of Allowed Charges after Deductible
• **Oxygen**	80% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Excludes services covered under the Preventive Care provision of the Plan.		

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.866.543.0277. See the section entitled Cost Management Services for details.

Service Type	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Benefits Level Three
Food Products (Aminoacidopathies Formula, Enteral Formulas, Modified Solid Food Products)	Not covered	Not covered	Not covered
Foot Care and Podiatry Services • **Visit**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Surgery**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Routine foot care is not covered. **Exception:** Routine foot care is covered for patients with severe systemic disorders, such as diabetes. Foot Orthotics are covered.		
Hearing Aid	Not covered	Not covered	Not covered
Hearing Exam	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Home Health Care ☎ • **Aide, Nurse or other Authorized Agency Employee**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Home IV Therapy and Respiratory Care**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limited to 40 visits per Covered Person per Calendar Year combined In- and Out-of-Network. One HHC visit equals: • Up to four hours of home health aide care; or • Each visit by other covered members of the HHC team. Services must be in lieu of Hospitalization or inpatient SNF care.		
Hospice Care	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limited to 210 days for an approved plan of care per Covered Person per Lifetime combined In- and Out-of Network. Bereavement counseling visits limited to five visits for covered family members.		
Hospital Facility • **Inpatient Hospital** ☎	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered.		
• **Outpatient Hospital** • Clinic	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Clinic room only; related services are allowed per service type (examples include but are not limited to X-ray and diagnostic testing).		
• Diagnostic Testing	See Diagnostic Testing	See Diagnostic Testing	See Diagnostic Testing

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.866.543.0277. See the section entitled Cost Management Services for details.

Service Type	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Benefits Level Three
• Emergency Room for Emergency Condition and Related Charges	Benefit Copayment 100% of Allowed Charges. Limit one Copay per length of stay.	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Notification to PCP must be made within 48 hours of a life threating emergency. Care must be received within 24 hours of a life threatening injury or illness and within 72 hours of an accidental injury. Network Copayment is waived if the Covered Person is admitted as an inpatient into the treating Hospital directly from the emergency room.		
• Outpatient Surgical Center	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• Other Outpatient Hospital Services and Supplies	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Impotency Treatment	See type of service rendered	See type of service rendered	See type of service rendered
Infertility Services (Medically Necessary)	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Benefit is limited to the diagnosis of Infertility only.		
In-Hospital/Facility Physician's Care	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Coverage is only provided for visits for days approved for a covered inpatient stay.		
IV (Infusion) Therapy	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Massage Therapy	Not covered	Not covered	Not covered
Maternity Care • **Initial Diagnostic Office Visit, Physician Charge**	Network Copayment then 100% of Allowed Charge	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Inpatient Hospital (Includes Birthing Center)**☎	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered. This benefit includes certified Birthing Centers. Maternity is covered the same as any other Illness.		
• **Prenatal, Delivery and Postpartum Care of Pregnancy, Physician Charges**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Related testing is covered separately per service type rendered (sonograms have no frequency limit).		
Medical/Surgical Supplies	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.866.543.0277. See the section entitled Cost Management Services for details.

Service Type	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Benefits Level Three
Mental Disorder Treatment • **Inpatient** ☎ • General Hospital or Private Proprietary Psychiatric Facility • Partial Hospitalization	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations.		
• **Inpatient, Physician Charge**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient/Office**	Network Copayment then 100% of Allowed Charge	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Services must be rendered and billed by a New York State licensed mental health professional performing services within the scope of their license. For services rendered and billed outside of New York State the Provider must be operating within the scope of their license and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health facility, Physician's corporation or clinic for the services of a similarly licensed Provider will be covered.		
• **Psychological Testing**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Newborn Care • **Circumcision**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Hospital**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Physician**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limited to Allowed Charges made by a Physician for routine pediatric care after birth while the newborn child is Hospital-confined up to four days. If the baby's routine care is extended due to the mother's continued stay, benefits will not be paid even if the mother was needed to provide basic care, such as breastfeeding. Routine newborn care billed by an anesthesiologist or the delivering Physician is not covered.		
Nursing, Private Duty	Not covered	Not covered	Not covered
Obesity Treatment, including Morbid Obesity	See type of service rendered	See type of service rendered	See type of service rendered
	Only the examination to diagnose obesity and Morbid Obesity will be covered. Treatment will not be covered.		

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.866.543.0277. See the section entitled Cost Management Services for details.

Service Type	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Benefits Level Three
Occupational Therapy			
• **Freestanding Facility**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient Hospital**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Physician Office**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Orthotics ☎Over $250	80% of Allowed Charges	50% of Allowed Charges after Deductible	50% of Allowed Charges after Deductible
Physical Rehabilitation Facility, Inpatient	100% of Allowed Charges	80% of Allowed Charge after Deductible	80% of Allowed Charges after Deductible
	Limit 60 days per Covered Person, per Calendar Year, combined all levels.		
Physical Therapy			
• **Freestanding Facility**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Inpatient Hospital**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient Hospital**	Network Copayment then 100% of Allowed Charges	50% of Allowed Charges after Deductible	50% of Allowed Charges after Deductible
• **Physician Office**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Maintenance Care is not covered.		
Physician Care			
• **Emergency Room**			
• Emergency Condition and Related Charges	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Home, Office, Clinic or Elsewhere**			
• Primary Care Provider (including family practitioner, general practitioner, OB/GYN, pediatrician, internist)	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Services must be given and billed by a covered healthcare Provider and found Medically Necessary according to Plan provisions in an office, clinic, home or elsewhere. Outpatient Mental Disorder care, outpatient Use Disorder care, outpatient consultations, surgical and obstetrical procedures, outpatient emergency room visits, rehabilitation therapy, Urgent Care Facility Physician charges and chiropractic care are not covered under this benefit.		
• **Urgent Care**	See Urgent Care Facility		

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.866.543.0277. See the section entitled Cost Management Services for details.

Service Type	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Benefits Level Three
(Physician Charges)			
Preadmission Testing	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Must be: o Performed on an outpatient basis within 14 days before a scheduled Hospital confinement; o Your Physician ordered the tests; and o Physically present at the Hospital for the tests. Covered Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.		
Prescription Drugs with COB	100% of Allowed Charges	100% of Allowed Charges	100% of Allowed Charges
Preventive Care • **Bone Density Testing**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Covered Persons allowed: o Previously diagnosed as having osteoporosis or having a family history of osteoporosis; o With symptoms or conditions indicative of the presence or the significant risk, of osteoporosis; o On a prescribed drug regimen posing a significant risk of osteoporosis; o With lifestyle factors to such a degree as posing a significant risk of osteoporosis		
• **Colorectal Cancer Screening**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Age 50 and older. Routine frequency for persons at average risk when recommended by a Physician: o Sigmoidoscopy – once every five years; or o Barium enema (double contrast) - once every five years; or o Colonoscopy - once every ten years; or o Fecal occult blood.		
• **Mammogram**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	o at any age for Covered Persons having prior history of breast cancer or whose mother or sister has a prior history of breast cancer; o Age 35 or over for Covered Persons; cover once a year.		
• **Prostate-Specific Antigen (PSA) and/or Digital Rectal Examination**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limit – One per year from age 50 (from age 40 for men at high risk) combined In- and Out-of-Network.		
• **Routine Adult**	Network Copayment	80% of Allowed Charges	80% of Allowed Charges

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Service Type	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Benefits Level Three
Physical (19 and above)	then 100% of Allowed Charges	after Deductible	after Deductible
• Immunizations	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Includes routine exam and related screening tests based on current medical standards for preventive care. Immunizations follow the recommendations set by the Department of Health and Human Services Centers for Disease Control (CDC). Limited to one exam per Calendar Year, per Covered Person for any combination of In- and Out-of-Network Providers. This maximum does not apply to other screening services listed above/below.		
• **Routine Child Care (Well Child) (up to age 19)**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Coverage for health care visits and related testing follows the guidelines of the American Academy of Pediatrics (AAP). Coverage for immunizations follows the recommendations set by AAP or as set by the Department of Health and Human Services Centers for Disease Control (CDC). Routine newborn care is covered as shown above.		
• **Routine Screening Cervical Cytology/ Pap Smear, and exam**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limited to one per Plan Year to include annual pelvic exam, collection and preparation of a pap smear, and professional evaluation of the pap smear. No copay for Pap Smear (included in office visit).		
• **Vision Exam**	Specialist Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limit one every 12 months per OnPoint and OnPoint MC Covered Persons and one every 24 months for OnPoint DSBA Covered Persons.		
• **Well Woman Visit**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limited to one per Plan Year.		
• Contraceptive Management	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Plan covers FDA-approved birth control medications and devices that require a prescription under the Prescription Drug Benefits.		
Prosthetics ☎ Over $500	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible

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Service Type	OnPoint Network Level One	POMCO PHCS/ MultiPlan Level Two	Out-of-Network Benefits Level Three
Pulmonary Rehabilitation			
• **Freestanding Facility**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient Hospital**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Physician Office**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Coverage is limited to a maximum of 36 visits per Covered Person per Lifetime for an approved plan of care combined In- and Out-of-Network. Related testing procedures will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits.		
PUVA (Psoralen & Ultraviolet Radiation Light Therapy)	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Radiation Therapy			
• **Freestanding Facility**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient Hospital**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Physician Office**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Refractive Surgery	Not covered	Not covered	Not covered
Respiratory/Inhalation Therapy			
• **Freestanding Facility**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient Hospital**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Physician Office**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Skilled Nursing Facility (SNF), Inpatient ☎	100% of Allowed Charges	80% of Allowed Charge after Deductible	80% of Allowed Charges after Deductible
	Limited to 100 days limit per Calendar Year. Admission must be seven days of a prior hospital stay. Combined In- and Out-of-Network. Room and Board charge limited to actual semi-private rate. Coverage for a private room will be limited to the facility's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered.		

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.866.543.0277. See the section entitled Cost Management Services for details.			
Service Type	**OnPoint Network Level One**	**POMCO PHCS/ MultiPlan Level Two**	**Out-of-Network Benefits Level Three**
• **Outpatient Services**	Benefits for outpatient SNF are the same as the benefits for outpatient Hospital diagnostic X-ray, laboratory, pathology, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, radiation therapy, and inhalation therapy services shown previously in this section.		
Speech Therapy • **Freestanding Facility**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient Hospital**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Physician Office**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Shock Therapy ☎ • **Inpatient**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Substance Use Disorder Treatment • **Detoxification**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Inpatient Facility** ☎ • General Hospital or Certified Alcohol/ Substance Use Disorder Facility Program • Partial Hospitalization	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations.		
• **Inpatient Physician**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Outpatient/Office**	Network Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Surgical Charge Benefit • **Assistant Surgeon**	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
• **Surgeon** ☎	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Please refer to the Cost Management Section for procedures that require precertification. Excludes services covered under the Infertility provisions of the Plan.		

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.866.543.0277. See the section entitled Cost Management Services for details.			
Service Type	**OnPoint Network Level One**	**POMCO PHCS/ MultiPlan Level Two**	**Out-of-Network Benefits Level Three**
Therapeutic Injections	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
TMJ	Not covered	Not covered	Not covered
Transplants	100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	See Master Plan document for specific covered transplants.		
Urgent Care Facility	Benefit Copayment then 100% of Allowed Charges	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Copayment waived if admitted. One combined Copay per date of service applies to all services billed by the facility/Physician. Includes all covered facility/ Physician charges performed in the Urgent Care Facility.		
Vision Therapy	Not covered	Not covered	Not covered
Voluntary or Elective Abortion	Not covered	Not covered	Not covered
Voluntary or Elective Sterilization	Not covered	Not covered	Not covered
Wig	100% of Allowed Charges	100% of Allowed Charges	100% of Allowed Charges
	Benefit limited to 1 per Lifetime with approved diagnosis. $400 maximum.		

Prescription Drug Benefits are generally separate from Medical Benefits and do not apply to the Deductibles, Copayments, and Out-of-Pocket limits for Medical Benefits.			
Any one retail Pharmacy prescription or refill is limited to a 30-day supply. Any one mail order prescription or refill is limited to a 90-day supply. Some covered Prescription Drugs have a quantity limit under the Plan. For additional information on medications that have quantity limits you may call ProAct Customer service at 1.877.622.8440.			
Covered Drugs and Supplies	**In-Network**		
Prescription Drug Benefit (ProAct)	**Note:** *You must pay applicable Copayments. The Plan pays the balance of the Allowed Charges.* Copayments per prescription:		
	OnPoint and OnPoint MC	**Retail**	**Mail Order**
	Generic	$7	$7
	Preferred Brand Name	25% ($20 minimum and $100 maximum).	$20
	Non-Preferred Brand Name	35% ($35 minimum and $125 maximum).	$40
	OnPoint DSBA	**Retail**	**Mail Order**
	Generic	$5	$5
	Brand Name	The greater of $10 or 20% cost.	$10
	Benefit includes coverage for: Oral contraceptives - Prior authorization required for DSBA. Retin A - Prior authorization required. Smoking Cessation - Prior authorization required oral 50% copayment. Chantix only. Viagra - 6 pills per 23-day quantity restriction - Prior authorization required.		

COMPREHENSIVE MEDICAL BENEFITS

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

This document is intended to describe the benefits provided under the Plan, but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Claims Administrator if you have questions about specific supplies, treatments or procedures.

DEDUCTIBLE

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

This amount will accrue toward the 100% maximum Out-of-Pocket payment.

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

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

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

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

BENEFIT PAYMENT

Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the Out-of-Pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges Incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the Out-of-Pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

COVERED CHARGES

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

MEDICAL SERVICES AND SUPPLIES

Allergy Care

Benefits are available for allergy treatment including, but not limited to, office visits, serum, scratch testing and laboratory testing. Allergy serum covered under the Prescription Drug Benefit will not be covered as a Medical Services and Supplies Benefit.

Ambulance Charges

The Allowable Charges billed by a local land ambulance service for trips to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary. In addition, land ambulance transportation from an inpatient (or other facility) to another facility (or other location) will be considered when found Medically Necessary and ordered by a Physician. Such transfers cannot be for the convenience of the patient or family members.

Charges for pre-Hospital medical Emergency Services are covered regardless of whether or not the Covered Person is actually transported to a Hospital.

Air ambulance may be reimbursed only when the patient's condition was so serious that the patient could not be transported safely by land ambulance. Air ambulance may also be reimbursed if the location from which the patient required emergency transportation was inaccessible by land ambulance.

Professional and volunteer ambulance must charge for its services.

Ambulatory Surgical Center

As defined, for outpatient surgery. Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge.

Anesthesia

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

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

Blood Services

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

Coverage also includes services related to blood donations, autologous (patient donates own blood) or directed (donation of blood by individual chosen by patient), when there is a scheduled surgery that customarily requires blood transfusions.

Cardiac Rehabilitation

For outpatient telemetric monitoring during exercise for cardiac rehabilitation rendered at a Hospital or free standing cardiac rehabilitation center. Services must be rendered by a Physician, or by a professional nurse trained in cardiac rehabilitation. Services must be ordered by the attending doctor and found Medically Necessary due to certain medical conditions, such as post valvular or congenital heart surgery; post heart transplants; dilated cardiomyopathy; post myocardial infarction; post bypass surgery or angioplasty; or stable angina. The plan of care must be approved for benefits by the Claims Administrator. The Claims Administrator may request medical records to evaluate the claim for Plan coverage.

This benefit is limited to expenses for telemetric monitored exercise for cardiac rehabilitation only. No other exercise programs are covered. Coverage is limited to frequency up to three times per week and up to a maximum 18 consecutive weeks for an approved plan of care. Related testing procedures such as stress tests will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits. Separate charges for use of exercise equipment are not covered.

Chemotherapy Benefits

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

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

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

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

Chiropractic Care

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

Consultations, Specialist

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

(1) **Inpatient Consultations.** Coverage is limited to one inpatient consultation per specialty for each inpatient stay.

(2) **Outpatient/Office Consultations.** Coverage for outpatient or office consultations is provided for as many specialty opinions requested by the attending Physician as Medically Necessary.

(3) **Second Opinion Consultation.** Benefits are available for patient-requested second opinion consultations before proceeding with a covered surgical procedure or treatment. The second opinion consultation must be given by a board-certified Physician specialist whose specialty is appropriate to consider the need for the proposed procedure. If the

consulting specialist renders the procedure, consultation benefits are not payable. If you or your Dependent seek a third opinion, benefits will be provided on the same basis as the second opinion. Whether or not the second (or third) opinion agrees that procedure is necessary, the Plan will cover the second opinion consultation. It is the patient's decision whether to undergo the procedure.

(4) **Second Medical Opinion.** Benefits are also available for a second medical opinion from a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of a course of treatment for cancer.

Contact Lens/Eyeglasses

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

Dental Care, Limited Coverage

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

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

Emergency repair due to Injury to Sound Natural Teeth within 12 months of the Injury.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth within 12 months of the Injury

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

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

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

Diabetic Supplies, Equipment and Education

(1) The following supplies and equipment are covered for the treatment of a diabetic condition when such supplies are ordered or recommended by a Physician and when they are found to be Medically Necessary according to the Plan provisions:

(a) Cartridges for the legally blind;

(b) Insulin and pen cartridges;

(c) Syringes;

(d) Alcohol swabs;

(e) Data management systems;

Items such as adhesive tape, and gauze are not covered. Insulin, oral agents to control blood glucose, syringes, and test strips are covered under the separate Prescription Drug Expense Benefits.

(2) Diabetic self-management education and education relating to diet may be covered for a

covered Person with a diabetic condition. Self-management education or diet instruction will only be covered when the patient is initially diagnosed with diabetes or when a Physician diagnoses a significant change in the patient's symptoms or condition that requires changes in the patient's self-management. These educational services will be covered when provided by:

(a) A Physician or his/her staff during an office visit for diabetes diagnosis or treatment. When the self-management service education is provided during an office visit, the one benefit payment for the office visit will include payment for the self-management education;

(b) A certified diabetes nurse educator, certified nutritionist or certified and registered dietician when referred by a Physician. This education must be provided in a group setting. If it is decided that group education is not available in the patient's area, the Plan may cover individual education;

(c) A professional Provider as described above may be covered for services rendered in the patient's home. However, it must be found to be Medically Necessary for the patient to receive services at home.

Diagnostic Testing, X-ray and Lab Charge Benefits

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

(1) Diagnostic radiology, ultrasound, nuclear medicine, and necessary supplies.

(2) Diagnostic medical services such as cardiographic and encephalographic testing, radioisotopic studies and other procedures which may be approved when performed and billed by a Physician or covered facility.

(3) Pathology tests (laboratory tests) when performed, billed for or ordered by a Physician or covered facility.

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

Charges for the following will not be included in this section:

(1) premarital exams;

(2) routine physical exams;

(3) X-ray therapy or chemotherapy; or

(4) exams performed as part of dental work, eye tests or fitting of lenses for the eye.

Dialysis

The Enrollee's first 40 renal dialysis visits are allowed at the Allowed Charges minus any applicable Enrollee cost share (i.e., Deductible, Copayment and/or Coinsurance). Additional visits are allowed up to 150% of the current Medicare allowed amount for the Medicare region in which services were performed or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge. Renal dialysis visits will not be subject to Out-of-Network limitations.

Benefits are available for service or supplies related to outpatient dialysis procedures given and billed by Physicians or Medicare-certified dialysis centers. Home self-dialysis is also covered when ordered by the attending Physician and home setting found medically appropriate according to Plan provisions. If you are on home dialysis, coverage includes related laboratory tests and consumable

or disposable supplies needed for the dialysis. Equipment found Medically Necessary by the Claims Administrator may also be covered. Benefits are not payable for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, or air conditioning, or for convenience or comfort items.

Note: Persons of any age who are diagnosed with end stage renal disease (ESRD) should contact the Social Security Office for Medicare eligibility and enrollment details. If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period).See the definition of Allowed Charges shown later in this document for benefit payment details under the Plan. Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

Durable Medical Equipment

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

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

Foot Care and Podiatry Services

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

Hearing Exam

Benefits are available for a hearing exam.

Home Health Care Services and Supplies

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

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

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

Hospice Care Services and Supplies

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

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

(1) Bed patient either in a designated Hospice Unit or in a regular Hospital bed or in a Skilled Nursing Facility;

(2) Day care service provided by the Hospice Agency;

(3) Home care and Outpatient Services provided by the Hospice including intermittent nursing by a registered nurse or licensed practical nurse or by a home health aide;

(4) Physical, occupational, speech, and respiratory therapy;

(5) Medical social services and nutritional services;

(6) Laboratory, X-ray, chemotherapy, and radiation therapy when needed to control symptoms;

(7) Medical supplies and drugs and medications considered approved for the patient's condition. Benefits are not payable if the drugs or medications are of an Experimental nature;

(8) Durable Medical Equipment;

(9) Medical care provided by the Hospice Physician or other Physician designated to render services by the Hospice Agency; and

(10) Bereavement counseling for the family, limited to five visits per family.

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

Hospital Charges

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

(1) **Inpatient Hospital Care.** The medical services and supplies furnished by a Hospital or a Birthing Center.

The Usual and Reasonable Charges for room and board are payable as described in the Schedule of Benefits.

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

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

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

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

The allowed charges for Hospital-billed medical services and supplies (other than room and board) and diagnostic X-rays and lab tests are payable.

Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual and Reasonable and Charge.

(2) Outpatient Emergency Accident Care and Emergency Medical Care.

(a) Emergency care for the initial treatment of traumatic bodily injuries resulting from an accident. Treatment must be rendered within 72 hours of the accident.

(b) Care for the initial treatment of a Medical Emergency, as defined in this Plan, within 48 hours of the onset of an accidental Injury or within 24 hours of a life threatening Injury or Illness.

(3) Outpatient Surgical Care.

(4) Clinic Services or Supplies.

(5) Other Services and Supplies such as prescription medication, vaccines, and biologicals, and supplies in conjunction with diagnostic and therapeutic services, and their administration.

Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge.

Infertility

Expenses related to the diagnosis of Infertility will be covered as any other Illness. Services to treat Infertility will not be covered.

In-Hospital/Facility Physician's Care Benefits

This benefit applies when a medical charge is Incurred for the care of a Covered Person's Injury or Sickness during a covered Hospital/facility confinement.

However, a medical charge will not include:

(1) a charge for care not rendered in the presence of a Physician; or

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

IV Therapy/Infusion Services

Ambulatory or home intravenous services ordered by a Physician to include intravenous medications, blood, hydration and electrolyte replacement, and total parenteral nutrition.

Maternity

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

Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). If you choose to be discharged from the Hospital before the recommended time frames noted above, you are eligible for one Home Health Care visit by a qualified Home Health Care Agency. This visit is separate and does not apply to any visit limits set under any other Home Health Care benefit. A Home Health Care maternity visit must be requested within 48 hours of the time of delivery (96 hours in the case of cesarean delivery). The visit must be rendered within 24 hours of discharge, or of the time of the request, whichever is later. The visit

should include parental education; assistance and training in breast or bottle feeding; and the performance of any necessary maternal and newborn clinical assessments. In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are available for services by a Physician or certified nurse midwife for childbirth, cesarean section, and other maternity care rendered for you or your Spouse/Dependents. Coverage is not provided for expenses connected with elective abortion. The Plan excludes service or supplies related to surrogate maternity care. The payment for childbirth or cesarean section will include the usual care given by a Provider before and after the obstetrical procedure (prenatal or postnatal care).

Medical Supplies (Home Use)

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

(1) Ostomy bags and supplies required for their use.

(2) Catheters and supplies required for their use.

(3) Syringes and needles necessary for conditions such as diabetes.

(4) Extensive surgical dressings necessary for conditions such as cancer, diabetic ulcers and burns.

(5) Compression stockings limited to two pair per Calendar Year, if determined to be Medically Necessary. Additional pair could be allowed if determined to be Medically Necesssary.

Mental Health Disorder Treatment

Covered Charges will include care, supplies and treatment of an approved treatment plan of Mental Disorders. Regardless of any limitations on benefits for Mental Disorders and Substance Use Disorders Treatment otherwise specified in the Plan, any aggregate Lifetime limit, annual limit, financial requirement, Out-of-Network exclusion or treatment limitation on Mental Disorders and Substance Use Disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable. Covered Charges for care, supplies and treatment of Mental Disorders will be limited as follows:

(1) **Inpatient Treatment.** Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

(2) **Outpatient Treatment.** Covered Charges for care, supplies and treatment of Mental Disorders will be limited as follows:

- Physician's visits are limited to one treatment per day.
- Services must be rendered and billed by a New York State licensed mental health professional performing services within the scope of their license. For services rendered and billed outside of New York State the Provider must be operating within the scope of their license, and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health facility, Physician’s corporation or clinic for the services of a similarly licensed Provider will also be covered.

Newborn Care

The benefit is limited to the Allowed Charges made by a Hospital or Physician for routine pediatric care while the newborn Child is Hospital-confined as a result of the Child's birth.

Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn Child is an eligible Dependent.

Obesity

The Plan will allow the examination to diagnose obesity and Morbid Obesity. The Plan will not allow weight loss drugs or surgical intervention.

Occupational Therapy

Services rendered by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

Orthotics

The initial purchase, fitting and repair of Orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Foot Orthotics are covered.

Oxygen

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

Physical Rehabilitation Facility, Inpatient

See Skilled Nursing Facility benefit.

Physical Therapy

Services rendered by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. If the patient reaches maximum potential for significant and measurable improved function, or if care is found by the Claims Administrator to be Maintenance in nature, benefits will no longer be payable.

Physician Care

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

Preadmission Testing

The Medical Benefits percentage payable will be for diagnostic lab tests and X-ray exams when:

(1) performed on an outpatient basis within 14 days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

Prescription Drugs (as defined)

(1) **When this Plan is Primary,** Prescription Drug Coverage is not available under the Medical Benefits portion of your Plan. Prescription Drug coverage is available through ProAct In-Network pharmacies under the Prescription Drug Benefits shown later in this document.

(2) **When this Plan is Secondary**, all covered drugs and medicines are covered under Medical Benefits. Then, Plan benefits are coordinated with the primary plan payments. Please refer to the section entitled Schedule of Benefits for benefit limits and Prescription Drug Benefits shown later in this document for details on covered expenses, limitations and exclusions.

Preventive Care Services

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

Preventive care services/routine well care is care by a Physician that is not for an Injury or Sickness.

(1) **Bone Density Screening.** Bone mineral density measurement or test to detect osteoporosis is covered for Covered Persons:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
- With such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis**.**

(2) **Colorectal Cancer Screening** for Covered Persons Age 50 and older. Routine frequency for persons at average risk when recommended by a Physician:

- Sigmoidoscopy – once every five years; or
- Barium enema (double contrast) - once every five years; or
- Colonoscopy - once every ten years; or
- Fecal blood occult.

Coverage is intended to be consistent with the guidelines for early detection screening and surveillance testing for colorectal cancer.

(3) **Gynecological Exam** based on guidelines of American College of Obstetricians and Gynecologists (ACOG) to include:

- Pelvic exam; and
- Ancillary tests that may be rendered during the routine GYN exam are covered such as, but not limited to, a urinalysis.

If ACOG standards or FDA guidelines change, the Plan will automatically cover their new recommendations.

(4) Mammography

- at any age for Covered Persons having prior history of breast cancer or whose mother or sister has a prior history of breast cancer;
- once a year for Covered Persons age 35 or over.

(5) Pap Smear/Screening Cervical Cytology based on guidelines of American College of Obstetricians and Gynecologists (ACOG) to include:

- Pap smear (age 18 and older); and
- HPV-DNA test (according to FDA-approved guidelines for routine screening).

(6) Prostate Exam. Benefits are available for routine screening of the prostate gland, including digital rectal examination and PSA (prostate-specific antigen) testing.

- Coverage is limited to once per Calendar Year for men from age 50.
- Coverage is available for men at any age who have a prior medical history of prostate cancer and for men age 40 and older if determined to be at high risk for prostate cancer. Such high risk factors include a family history of prostate cancer and/or African-American ancestry

(7) Routine Adult Physical Exams, to include screening tests and age-appropriate immunizations.

(8) Routine Well Child Care is routine care by a Physician that is not for an Injury or Sickness, to include health care visits and immunizations.

Coverage is intended to be consistent with the clinical standards set forth by the ACIP (Advisory Committee on Immunization Practices) of the Centers for Disease Control and Prevention and the American Academy of Pediatrics, recommendations. If these standards change, the Plan will automatically cover the new recommended standards.

(9) Well Woman Exam. Includes pelvic exam and ancillary tests that may be rendered during the routine gynecological exam to include, but not limited to, a urinalysis.

- **Contraceptive Management:** Medical benefits portion of the Plan covers: Allowable Charges related to Physician or clinic contraceptive services, including the measuring, fitting or insertion or removal of covered devices and the purchase of covered devices, are covered. This is covered as a service of the professional Provider who administers them.

  Prescription Drug benefits portion of the Plan covers: All FDA-approved, Physician prescribed l contraceptives.

  Benefits are not provided for any drug or device obtainable without a prescription. Male contraceptive medicines or devices are not covered, regardless of intended use.

Prosthetics

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

Pulmonary Rehabilitation

Is covered when found Medically Necessary and the services are performed by a Pulmonary Rehabilitation program approved by the Claims Administrator. Patients must meet the Medical Necessity criteria for Pulmonary Rehabilitation of the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) for patients with chronic pulmonary disease. The plan of care

must be approved for benefits by the Claims Administrator prior to the start of treatment. The Claims Administrator may request medical records to evaluate the claim for Plan coverage.

Coverage is limited to a maximum of 36 visits per Covered Person per Lifetime for an approved plan of care. Related testing procedures will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits.

PUVA

Psoralen and Ultraviolet A is a therapy that the patient is exposed first to psoralens (drugs containing chemicals that react with ultraviolet light) and then to UVA light, when proven to be Medically Necessary.

Radiation Therapy Benefits

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

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

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

Respiratory/Inhalation Therapy

For short-term outpatient respiratory/inhalation therapy when ordered by the attending Physician for therapy services given by certified licensed respiratory therapists or other qualified Provider. Custodial Care or Maintenance Care is not covered.

Shock Therapy

The Plan will allow Medically Necessary shock therapy.

Skilled Nursing Facility (SNF) Care

(1) **Inpatient SNF Services.** 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) the confinement starts within seven days of a Hospital confinement;

(c) the attending Physician certifies that the confinement is needed for further care;

(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.

Covered Charges for a Covered Person's care in these facilities is limited to the covered daily maximum shown in the Schedule of Benefits.

(2) **Outpatient SNF Services**.

(a) **Rehabilitative Therapy**. Benefits are available for outpatient physical therapy, cardiac rehabilitation, occupational, speech therapy and inhalation/respiration therapy rendered to improve function lost due to an Illness or Injury. Such care must be ordered by the attending Physician and rendered by Professional Healthcare Providers licensed to render such care. Refer to the Schedule of Benefits for benefit limits.

(b) **Other Outpatient Services and Supplies.** Benefits are available for other outpatient facility service or supplies when found Medically Necessary according to Plan provisions. Coverage includes all necessary supplies used during the covered treatment.

Speech Therapy

Services rendered by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (b) an Injury; or (c) a Sickness that is other than a learning or Mental Disorder. If the patient reaches maximum potential for improved, or age appropriate, function, benefits will no longer be payable.

Substance Use Disorder Treatment

Covered Charges will include care, supplies and treatment of Substance Use Disorder for services by a certified Substance Use Disorder Facility (freestanding agency or facility or a Hospital center) for an approved plan of inpatient or Outpatient Care. Regardless of any limitations on benefits for Mental Disorders and Substance Use Disorder Treatment otherwise specified in the Plan, any aggregate Lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Use Disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

(1) **Inpatient Treatment.** Inpatient detoxification is considered a medical condition eligible for acute care Hospital benefits. Expenses for inpatient Substance Use Disorders (alcohol or drug abuse) rehabilitation are covered separately from detoxification.

Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

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

Family therapy is allowed for covered family members.

Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

Surgical Charge Benefits

(1) **Assistant Surgeon.** Charges for assistant surgeon services are covered when found Medically Necessary for performance of the covered procedure. The maximum payment for all assistant surgeons for each surgical procedure is 20% of the value listed for surgery.

(2) **Surgeon.** This benefit applies when a surgical charge is Incurred for a surgical procedure that is performed as the result of a Covered Person's Injury or Sickness and while that person is covered for this benefit.

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

(a) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowed Charge for the primary procedures; 50% of the Allowed Charge for each additional procedure performed in the same area of the body or through the same incision. Any procedure that would not be an integral part of the primary procedure or is

unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowed Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowed Charge for that procedure.

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

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

(a) reconstruction of the breast on which a mastectomy has been performed,

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(c) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

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

Transplants - Organ/Autologous Bone Marrow/Stem Cell Transplants

Benefits are available for expenses related to non-Investigational organ or tissue transplants the same as any other Illness. Unless otherwise specifically included, transplants are considered Investigational unless specifically included for Medicare coverage by the Centers for Medicare & Medicaid Services (CMS). Transplants must meet the Medicare criteria for coverage to be considered for coverage under this Plan. Benefits are not available for expenses related to transplants that have not been approved by CMS or that fail to meet CMS criteria for coverage. Plan coverage for Hospitals will be based on the same criteria set forth by CMS criteria. If CMS restricts coverage for a transplant to approved Hospitals only, then this Plan will only cover those transplants when rendered in the approved Hospital.

Benefits will be available for the following in connection with a covered transplant.

(1) **Recipient Expenses**. Coverage includes all Plan benefits available for Medically Necessary care and treatment related to covered organ transplants including, but not limited to; pre-transplant care including evaluation, diagnostic tests and X-rays by the transplant Hospital; procurement/tissue harvest and preparation; recipient's transplant surgery and recovery; and post discharge care.

(2) **Donor Expenses**.

(a) Coverage includes expenses Incurred by the live donor(s) for expenses related to procurement of an organ and for transportation of the organ(s) *to the extent such charges are not reimbursed by the donor's plan.*

(b) If you or your Dependent act as a donor, the donor expenses ***will not*** be covered by this Plan unless the recipient is a Covered Person under the Plan. Then, donor expenses will be considered as part of the organ recipient's claim.

Donor charges and donor search charges will be deemed to be Incurred on the date of the transplant even if the services were rendered before such date. No benefits will be

paid for pre-transplant testing in connection with a search for a donor who is not a family member.

(3) **Autologous Bone Marrow/Stem Cell.** Courses of treatment involving high dose chemotherapy or radiotherapy and autologous bone marrow, stem cell rescue, or other hematopoietic support procedures are not covered as organ and tissue transplants, except for the following (and only then for candidates who meet established national health and age standards): acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, and neuroblastoma as allowed under CMS guidelines. If CMS guidelines change, adding or deleting coverage under Medicare, this Plan will include or exclude those procedures. Recipient and donor expenses for covered procedures will be considered on the same basis as organ transplants shown above.

Urgent Care Facility

As defined. The Plan covers covered services and supplies provided by a legally operated emergency clinic or center for minor outpatient emergency medical care or emergency minor surgery. An outpatient Hospital emergency room does not qualify as an Urgent Care Facility.

Vision Exam, Including Refraction

Covered Person are allowed a routine vision exam, including refraction through OnPoint. This benefit is limited to every 12 months for OnPoint and OnPoint MC Covered Persons and every 24 months for OnPoint DSBA Covered Persons. A specialist Copay will apply. Additional benefits may be available through Davis Vision.

Wigs

Charges associated with the initial purchase of a wig for approved diagnoses. Limited to $400 per Lifetime.

DEFINED TERMS

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

Active Employee is an Employee who is on the payroll of the Employer and who has begun to perform the duties of his or her job with the Employer.

Advanced Physician Care Extender or Physician Extender includes Physician assistants (PAs), nurse midwives, nurse practitioners (NPs) and advanced practice nurses (APNs). These Providers are generally overseen by Physicians and must be licensed and regulated by a state or federal agency and acting within the scope of his or her license.

Allowed Charge (or Allowed Expense, Allowed Fee) - The Usual and Reasonable Charges as determined by the Claims Administrator for Covered medical services rendered and billed by a covered out-of-network Provider. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. If Medicare is primary, the Allowed Charge could be based on Medicare's allowance or limiting charges. **Exception:** When Medicare is the secondary payer under the Medicare Secondary Payer rules for ESRD (based on the Covered Persons eligibility, not their enrollment in Medicare), the Allowed Charges for covered outpatient renal dialysis services are payable up to 150% of the current Medicare allowable amount for the Medicare region in which services were performed or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge.

The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

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

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

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

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

Brand Name means a trade name medication.

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

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

County means the County of Onondaga of New York State in its capacity as an Employer and as Plan Administrator and Plan Sponsor of this Plan.

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

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

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

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

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

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

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

Emergency Medical Condition - a serious medical condition or behavioral condition after the onset of acute symptoms that were sudden and of such severity and/or pain that a prudent person, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention could result placing the person in serious jeopardy to the health of an individual (including the health of a pregnant woman or her unborn child) or others, if severe behavioral condition; impairment to bodily function; dysfunction of any organ; or serious disfigurement.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services to evaluate an Emergency Condition and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

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

Employer is the County of Onondaga.

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

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

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

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

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

If any of the entities used to determine the Investigational status of a drug, device, supply, treatment or any other medical service reverses, modifies, or establishes its policy for such expenses, and makes such changes retroactive, the Plan will not make payment for related retroactive Incurred expenses. The Plan will not seek refund for its previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

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

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

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

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

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

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping

services); physical, occupational and speech therapy; medical social services; medical supplies; and laboratory services by or on behalf of the Home Health Care Agency.

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

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

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

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

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

Hospitalist is a Physician that assumes the care of a Hospitalized patient and acts as a primary doctor while a patient is in a Hospital.

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

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

(1) Spouse of the patient or Enrollee;

(2) Natural or adoptive parent, Child or sibling;

(3) Stepparent, stepchild, stepbrother or stepsister;

(4) Father-in-law, mother-in-law, brother-in-law, or sister-in-law;

(5) Grandparent or grandchild; or

(6) Spouse of grandparent or grandchild.

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

Infertility means incapable of producing offspring.

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

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment

which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

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

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

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

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

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

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

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

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

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

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

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

Network Counties are the following New York counties: Allegany, Broome, Cayuga, Chemung, Chenango, Cortland, Delaware, Jefferson, Lewis, Livingston, Madison, Oneida, Onondaga, Ontario, Oswego, Otsego, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne and Yates; and the following Pennsylvania counties: Bradford, Susquehanna, and Tioga.

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

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

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

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

Partial Hospitalization (PHP) program or day/night program is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Health Disorder or Substance Use Disorder when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator, and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts at least 20 hours per week and no charge is made for room and board. Partial Hospitalization also encompasses partial hospitalization programs that provide overnight boarding.

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

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

Plan means the Onondaga County Point of Service Health & Wellness Plan or OnPoint, which is a benefits plan for certain Active Employees and Retired Employees of the County and is described in this document.

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

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

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

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

Primary Care Physician (PCP) means a Physician who is licensed in the state they are rendering services as a Family Practitioner, General Practitioner, Internist, Pediatrician, or Doctor of Osteopathy (D.O.) and is responsible for coordinating and overseeing the primary medical care for the Covered Person covered under this Plan. In addition to a PCP, women may also choose an Obstetrician/Gynecologist from the list of Level One Providers.

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

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

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

Pulmonary Rehabilitation is an individualized therapeutic multidisciplinary program of care for patients with chronic respiratory disease who remain symptomatic or continue to have decreased function despite standard medical treatment. Pulmonary Rehabilitations' goals are to reduce symptoms, optimize functional status, increase participation, and to train patients to successfully manage their disease process, and improve the overall quality of life for patients with chronic respiratory disease.

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

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

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

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

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

(8) It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a national accreditation organization recognized by the Claims Administrator.

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

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

Spouse shall mean the person recognized as the covered Employee's:

(a) husband or wife of the opposite gender under the laws of the jurisdiction or state where the covered Employee lives; or

(b) husband or wife of the same gender when there has been a marriage that is legally valid in the jurisdiction in which it occurred and the couple possesses a valid marriage license or certificate from the jurisdiction.

A legally separated Spouse may be enrolled in the Plan, but a divorced Spouse is not eligible. The Plan Administrator may require documentation proving a legal marital relationship.

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

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

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint.

Total Disability (Totally Disabled) means:

In the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. The Employer will determine Total Disability.

In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

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

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

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the Provider of the care or supply and does not exceed the usual charge made by most Providers of like

service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

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

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

Waiting Period means the time between the first day of employment and the first day of coverage under the Plan.

PLAN EXCLUSIONS

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

For all benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered.

(2) **Acupuncture.** Office visits, treatment, and related services and supplies rendered by an acupuncturist, whether or not licensed and regulated by a government agency.

(3) **Anesthesia.** Services or supplies for the administration of anesthesia for any surgery or treatment that is not covered by the Plan.

(4) **Automobile Insurance, No-Fault Auto Insurance** for which the Covered Person is eligible to receive benefits through mandatory No-Fault or fault automobile insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. This applies whether or not a claim is made for payment under that coverage. Benefits under this Plan will automatically be denied if the No-Fault Auto Insurance or other payer of motor vehicle liability coverage denies benefits due to its DWI or DUI exclusion, felony exclusions, as not Medically Necessary, or for late filing. Charges for services or supplies not paid by the No-Fault coverage due to its deductible or maximum payment limits will be covered under this Plan to the extent Allowable Fees would have otherwise been payable by this Plan. **Note:** No-Fault and motor vehicle liability coverage is considered another plan under the Coordination of Benefits provision of this Plan.

(5) **Biofeedback.**

(6) **Complications of Non-Covered Treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered

(7) **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of a, or as a result of, cosmetic surgery (including re-implantation). Services or supplies connected with elective cosmetic surgery or treatment. Reversal of elective, cosmetic surgery will not be covered unless found to be Medically Necessary according to Plan provisions. Exception: Care required to significantly restore tissue damaged by an Illness or Injury or for reconstructive surgery that is incidental to or follows surgery resulting from a trauma (surgery must Incur within two years after an accident), an infection or other disease of the involved part or reconstructive surgery because of a congenital disease or anomaly of a Dependent Child that has resulted in a functional defect.

(8) **Counseling/Analysis/Support Groups**. Services or supplies primarily directed at raising the level of consciousness, social enhancement, counseling limited to everyday problems of living such as marriage counseling, family counseling, pastoral counseling; gender identity counseling, sex therapy, or support groups.

(9) **Custodial Care.** Services or supplies provided mainly as a rest cure, Maintenance or Custodial Care or domiciliary care consisting chiefly of room and board.

(10) **Dental Care.** Services or supplies related to care or treatment of the teeth, gums or alveolar process, such as dental caries (tooth decay), extractions whether simple or surgical, periodontics, bridges, crowns, orthodontia, implants or other services

considered to be dental, rather than medical, in nature. Adjustments, services or supplies related to appliances for treatment of Temporomandibular Joint disorders (TMJ) or similar disorders.

Exceptions: Charges by a Dentist or Physician for care otherwise considered medical such as reduction of fractures of the jaw or facial bones, surgical correction of cleft lip, cleft palate, removal of stones from salivary ducts, bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues, treatment and surgery for joint disorders, freeing of muscle attachments. Limited dental care given for Accidental Injury to Sound Natural Teeth within 12 months following the accident; in no event will the Plan pay for the repair or replacement of dentures, crowns or other dental devices.

Benefits are also available for Hospital or other facility charges for dental-related services that require a Hospital inpatient or outpatient admission due to an underlying medical condition.

(11) **Durable Medical Equipment/Braces/Prosthetics/Devices.** Services or supplies related to duplicate medical equipment, braces, Prosthetics or other devices or the replacement of Durable Medical Equipment, braces, Prosthetics or other devices due to loss, theft or destruction, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional. The purchase of Durable Medical Equipment that can be rented unless the length of time that the equipment will be needed makes the purchase less costly than the rental. The purchase or replacement of any Biomechanical Prosthetic Device. Deluxe or specialized equipment when standard equipment is adequate for the patient's condition. Services or supplies related to durable equipment, braces, Orthotics, or splints that are primarily for athletic use.

(12) **Educational/Cognitive/Therapy for Developmental/Birth Defects.** Services or supplies related to special education or cognitive therapy for any reason, or for occupational, physical, psychological or other therapy that is primarily directed at educational or mental or physical development for learning deficiencies, mental retardation, developmental disorders, birth defects, autism, spinal bifida, educational or occupational deficits or perceptual and conceptual dysfunctions. This applies whether or not associated with manifest mental Illness or other disturbances. Services or supplies considered remedial or educational. Services and supplies that any school system is required to provide under any law. This applies even if the Covered Person, parent or guardian does not seek provision of such services or supplies through the school system.

(13) **Excess Charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(14) **Exercise Programs.** Exercise programs for treatment of any condition, except for Physician- supervised cardiac rehabilitation, approved Pulmonary Rehabilitation programs, occupational or physical therapy covered by this Plan.

(15) **Experimental or Not Medically Necessary.** Care and treatment that is either Experimental/ Investigational or not Medically Necessary, unless as required by federal law.

(16) **Eye Care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions (unless otherwise specified as covered by the Plan) and lenses for the eyes and exams for their fitting. Services and supplies related to vision therapy. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(17) **Foot Care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails

(unless needed in treatment of a metabolic or peripheral-vascular disease). Orthopedic shoes or other supportive foot devices.

(18) **Foreign Travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(19) **Government Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(20) **Government Facilities/Institutions.** Services or supplies received in an institution owned or operated by federal, state or local governments. However, benefits will be available for covered expenses for the following exceptions:

(a) Veterans Hospital for services and supplies that are unrelated to conditions resulting from military service in the USA armed forces.

(b) State or local government owned acute care Hospital or Skilled Nursing Facility that customarily bills for its services.

(c) State or local government owned mental health facility.

(d) Government owned facility that otherwise meets Plan limitations for coverage as an outpatient alcohol or Substance Use Disorder treatment facility.

(e) USA military acute care Hospital or Skilled Nursing Facility for treatment of retired or inactive military personnel or their dependents or for the dependents of active military personnel.

(f) Any government facility, if the patient with a sudden and serious Illness or Injury is treated immediately at a government facility, because of its closeness, and the confinement is only as long as the emergency care is necessary or it is impossible to transfer the patient to another facility.

(21) **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs with approved diagnoses. **Note:** The initial visit to diagnose alopecia will be covered.

(22) **Hearing.** Services or supplies related to hearing aids, tinnitus masking devices (or similar devices), communication devices, and examinations to determine the need for, adjustments or repair of them. Exceptions: The initial hearing aid for hearing loss caused by a covered surgical procedure rendered to a patient while he is covered under the Plan; services covered under the well adult or well child sections of this Plan and F.D.A. approved cochlear implant will be covered under the Plan's Prosthetic benefit.

(23) **Hospital/Facility Employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital, Skilled Nursing Facility, or any inpatient facility where care is received and paid by the Hospital or facility for the service. **Exception:** Hospitalists and Physician Extenders who have contracts for payment with the Claims Administrator.

(24) **Illegal Acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(25) **Illegal Care.** Services or supplies considered illegal according to the laws of the state of jurisdiction or according to federal law. Benefits will not be provided if these excluded services are obtained outside the USA even if these services are legal in the foreign country.

(26) **Immediate Relative or Self Giving Professional Services.** Professional services performed by a person who ordinarily resides in the Covered Person's home, or self, or is related to the Covered Person as a Spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law.

(27) **Implants.** Claims for eligible implants billed by a facility may be denied unless they are submitted with the invoice.

(28) **Infertility**. Care, supplies, services and treatment for Infertility, artificial insemination, or in vitro fertilization.

(29) **LaMaze (type) Classes** – child bearing classes.

(30) **Military Service.** Services or supplies for which benefits are, or can be, provided due to related Illness or Injury arising from the past or present military service in the armed forces of any government or international authority.

(31) **Missed Appointments/Phone Consultations/Forms/No Care Given.** Medical summaries, invoice preparation, completion of claim forms, or fees for missed appointments, telephone consultations, charges for standby services. Services or supplies not actually received by the patient or Incurred by someone other than the patient unless specifically included in this Plan such as coverage limits for organ donors.

(32) **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(33) **No Obligation to Pay.** Charges Incurred for which the Plan has no legal obligation to pay.

(34) **No Physician Recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(35) **Non-Emergency Hospital Admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(36) **Non-Traditional** medical services, treatments and supplies (e.g., alternative medicine, hypnosis) which are not specified as covered under this Plan.

(37) **Not Specified as Covered.** Medical services, treatments and supplies which are not specified as covered under this Plan.

(38) **Nursing Care,** even if order by your PCP, Physician or healthcare professional.

(39) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Medically Necessary surgical and non-surgical charges for Morbid Obesity are not covered. **Exception:** The Plan will allow the examination to diagnose obesity and Morbid Obesity.

(40) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. Payment will not be made even if you or your Dependents do not claim the entitled benefits.

(41) **Other Plan/Benefit Penalties/Primary Care Network/HMO Network**. Services or supplies to the extent such expenses were disallowed by a primary health Plan due to failure by their Enrollee or participant to follow the requirements of its benefit management or managed care program, preadmission reviews, second surgical opinion, or any other reason, including failure to abide by the primary care Physician network established by a health maintenance organization that is a primary plan payer.

(42) **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, support stockings, non-Prescription Drugs and medicines, first-aid supplies and non-Hospital adjustable beds, as well as telephone, radio, television, or barber services charged by any facility or other Provider.

(43) **Plan Design Excludes.** Charges excluded by the Plan design as specified in this document.

(44) **Police Custody/Court Ordered Services**. Services or supplies Incurred while the Covered Person is in police custody, jail or in prison, or services or supplies related to court ordered evaluations for Mental Disorders or substance (drug and alcohol) abuse.

(45) **Prohibited Referral**. Any Pharmacy services, clinical laboratory, radiation therapy, X-ray or imaging services which were provided pursuant to a referral prohibited by the New York State Public Health Law or similar laws in other states, if service is rendered out of New York.

(46) **Routine Care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(47) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(48) **Services Before or After Coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(49) **Sex Changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(50) **Sleep Disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(51) **Smoking Cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches.

(52) **Subrogation/Third Party Claim.** Services or supplies for which payment is received or are reimbursable because of claim settlement or legal action (third party claim or actions) other than from an insurance carrier under an individual policy issued to you or your Dependent. Exception: Conditional payments shown in the section entitled Third Party Recovery Provision.

(53) **Surgical Assistance**. Expenses billed for surgical assistance in a Hospital if the Hospital has qualified staff Physicians to provide such assistance. Expenses billed for surgical assistance by Providers other than qualified surgeons (M.D., D.O., or a D.P.M for foot surgery, or a D.D.S., D.M.D. for covered oral surgery).

(54) **Surgical Sterilization.** Care and treatment for surgical sterilizations or their reversal.

(55) **Surrogate Pregnancy.** Services or supplies related to surrogate maternity care, including but not limited to, those needed to initiate a Pregnancy, prenatal care, delivery or other procedures, and postnatal care or any other related care of the Pregnancy. Benefits are available for newborns who meet the Child eligibility requirements and who are enrolled under family coverage.

(56) **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge or transportation services specifically listed in this Plan.

(57) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. ProAct, the Pharmacy Benefit Manager (PBM), is the administrator of the Pharmacy drug plan.

Copayments

The copayment is applied to each covered Pharmacy drug or mail order drug charge and is shown in the Schedule of Benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one Pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

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 amounts shown in the Schedule of Benefits will be the ingredient cost and dispensing fee.

Percentages Payable

The percentage payable amount is applied to each covered Pharmacy drug or mail order drug charge and is shown in the Schedule of Benefits. This amount is not a Covered Charge under this Plan or the medical plan.

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.

Preauthorization Requirements

Some drugs require preauthorization before benefits become available. The participating Pharmacy or mail order Pharmacy will not provide coverage unless drugs have been approved for benefit payment. If a Pharmacy advises you that you need preauthorization, you should call Customer Service Department at 1.877.622.8440 for assistance. Failure to obtain prior authorization will result in denial of benefits.

Quantity Limits

Some drugs have quantity limits. The participating Pharmacy or mail order Pharmacy will not provide coverage unless drugs beyond those limits. You can call Customer Service Department at 1.877.622.8440 to determine if your drug has limitations.

Specialty Pharmacy Services

The PBM has a special program for specialty drugs developed for chronic and or complex Illnesses including but not limited to Crohn’s disease, hepatitis C, osteoarthritis, rheumatoid arthritis, Infertility, and pulmonary disease. These drugs may have special handling storage, shipping requirements, or require disease specific treatment programs. They may be injections, infusions, or oral products.

All drugs deemed specialty drugs by the PBM and received by the PBM’s mail order will be sent to the PBM’s Specialty Pharmacy to be filled. A complete list of drugs available under the specialty Pharmacy is available by calling the PBM’s Customer Service Department’s toll-free number: 1.877.622.8440 or you may access the list on their website at www.ProActrx.com

Vacation Supply

A supply of medication may be replenished before a normal refill date when needed for a vacation trip. To obtain authorization for an advance supply of drugs, you must phone the PBM toll-free at 1.877.622.8440. This means that you may receive up to a 90-day supply, limit one fill per Calendar Year. You must pay the applicable multiple Copayments for a vacation supply.

Generic Drug Substitution Program

As part of a continuing effort to control costs and preserve the quality of the Plan, you are encouraged to use Generic Drugs whenever appropriate for your condition. A Generic Drug is chemically equivalent to the original Brand Name Drug. The only difference is that the Brand Name manufacturer's patent has expired, allowing other manufacturers to sell the drug. As a result, the Generic manufacturer does not incur research costs and can charge significantly less for the drug. Since Generic Drugs cost less than Brand Name Drugs, cost savings result for you (a lower percentage payable liability amount) and the Plan when you substitute the lower priced drug. If you have any questions about Generic Drugs, ask for advice from your Physician or your pharmacist.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law, but excludes any drugs stated as not covered under this Plan. This includes all FDA-approved contraceptives that require a prescription for all Covered Persons.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection.

(5) Blood glucose monitors and test strips, lancet devices, insulin pump.

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.

(3) Quantity limits that could apply to controlled substances based on state regulations.

Expenses Not Covered

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

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite Suppressants/Dietary/Vitamin Supplements.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed. Vaccinations are covered.

(4) **Devices.** Devices of any type, even though such devices may require a prescription, excluding Physician-prescribed contraceptive devices, unless as indicated above as a

covered item. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs Used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Fluoride**. Dental fluoride products, except vitamin supplements containing fluoride prescribed for children to age five years.

(9) **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(10) **Immunization.** Immunization agents or biological sera. **Note:** Covered immunizations performed at the pharmacy will allowed.

(11) **Infertility.** A charge for Infertility medication.

(12) **Injectable Supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

(13) **Inpatient Medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(14) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".

(15) **Medical Exclusions.** A charge excluded under Medical Plan Exclusions.

(16) **No Charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(17) **No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or drugs indicated by the Plan (e.g., non-sedating anti-histamines).

(18) **Off Label Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(19) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO SUBMIT A CLAIM

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

Network Provider benefits are always paid directly to the Network Provider. Benefits for Hospital or other facility are generally paid directly to the Hospital or facility, if charges have not been paid by you. All other Allowed Charges/benefits are generally paid directly to you unless you direct payment to the Provider with written authorization. You may not assign your right to take legal action under this Plan to any Provider of service. Direct payments to a Provider, Physician or Hospital does not constitute a waiver of this anti-assignment provision.

When the claim is processed, POMCO will prepare an Explanation of Benefits Statement. This information should be carefully reviewed to make sure the charges were submitted to POMCO correctly and that the claim was processed accurately.

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

(1) Obtain a Claim form from the Office of Employee Benefits, OCC's Office of Human Resources or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician or Dentist complete the Provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Member ID number
- Name of patient
- Name, address, telephone number of the Provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

POMCO
2425 James Street
Syracuse, New York 13206
1.866.543.0277

WHEN CLAIMS SHOULD BE FILED

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

(1) it's not reasonably possible to submit the claim in that time; and

(2) the claim is submitted within one year from the date of the other's carrier explanation of benefits. This one year period will not apply when the person is not legally capable of submitting the claim.

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

CLAIMS REVIEW PROCEDURE

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

(1) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Enrollee ID number, the name of the patient and the Group Identification Number, if any.

(2) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

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

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

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

Second Step Appeal

If you disagree with the decision made by the POMCO Appeals Unit, you may submit a written appeal to the County. This written request to the County within 30 days after the date you receive POMCO's appeal decision. When requesting this second review, please state the reason you believe the claim was improperly denied and submit any data, questions or comments you deem appropriate. This written request for the County to review the POMCO appeal decision should be mailed to the County of Onondaga Employee Benefits Department.

COORDINATION OF BENEFITS

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

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

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

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans or programs required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

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

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

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

For Medicare integration, see section below.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits and vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow the National Association of Insurance Commissioners (NAIC) model regulations for coordination of benefits. Current regulations are shown below. If these regulations change, the Plan will automatically follow the amended regulations.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an

employee, member, subscriber, policyholder, or retiree) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of either a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

- **(i)** The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- **(ii)** If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

- **(i)** This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
- **(ii)** This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.
- **(iii)** This rule will be in place of items **(i)** and **(ii)** above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.
- **(iv)** If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.
- **(v)** For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situation in which a person who is covered a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not

the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period). Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a state child health plan to the extent required by federal law.

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

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

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

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

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

MEDICARE

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

(1) **Medicare Payment Integration**. The Plan determines its benefits in the absence of Medicare, and then pays the difference between its usual benefits and Medicare's benefits.

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

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

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

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

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

Allowable Fees for Medicare Integration Only Will be Based on the Following:

(1) If the Provider accepts Medicare assignment of benefits, the Allowable Fees will be the same fees allowed by Medicare.

(2) If the Provider does not accept Medicare assignment, the Allowable Fees will be based on the Usual and Reasonable Charges for Out-of-Network Providers and Network Providers or the charges determined by Medicare limiting charge regulations, whichever is the lower charge.

(3) If the Provider provides services under a Medicare Private Contract Option, Allowable Fees will be based on the Usual and Reasonable Charges, if applicable for services covered by this Plan.

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this Provision Applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. The Plan Administrator may, at its option, deny all charges or authorize conditional interim benefit payments for medical or dental expenses that would otherwise be covered by the Plan. However, any advance payments are subject to the Plan's subrogation rights. Accepting benefits under this Plan for those Incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer, including but not limited to the Covered Person's insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) cannot assign any rights against any Third Party or insurer without express written consent of the Plan; and

(3) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

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

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

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

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

Defined Terms: "Covered Person" means anyone covered under the Plan, including minor Dependents.

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

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

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

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

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

Rights of Plan Administrator. The Plan Administrator has a right to deny or make conditional payments, and to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The Plan Administrator is Onondaga County, John H. Mulroy Civic Center, 421 Montgomery Street, 14th Floor, Syracuse, New York 13202, telephone 315.435.3346. COBRA continuation coverage for the Plan is administered by POMCO, 2425 James St., Syracuse, New York 13206, 315.432.9171. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

There May be Other Options Available When You Lose Group Health Coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower Out-of-Pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

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

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

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan eligibility provisions.

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

A same-sex spouse is covered as a Qualified Beneficiary under federal law as of September 16, 2013.

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

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

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).

(6) A Dependent Child or Spouse who is terminated during Open Enrollment.

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

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

What Factors should be Considered When Determining to Elect COBRA Continuation Coverage? You should take into account that a failure to continue your group health coverage will

affect your rights under federal law.

First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Please note: pre-existing condition exclusions will become prohibited for Plan Years beginning on or after January 1, 2014 under the Patient Protection and Affordable Care Act.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

Are There Other Coverage Options Besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

What is the Election Period and How Long Must it Last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

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

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) enrollment of the Employee in any part of Medicare; or

IMPORTANT:

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

coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

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

Onondaga County
John H. Mulroy Civic Center
421 Montgomery Street
15th Floor, Employee Benefits Department
Syracuse, New York 13202

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

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

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

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

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost (if under your plan the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later (e.g., at the end of the month)). If you or your Spouse or Dependent Children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

Is COBRA Coverage Available if a Qualified Beneficiary has Other Group Health Plan Coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). Please note: pre-existing condition exclusions will become prohibited for Plan Years beginning on or after January 1, 2014 under the Patient Protection and Affordable Care Act.

When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an

interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary. Please note: pre-existing condition exclusions will become prohibited for Plan Years beginning on or after January 1, 2014 under the Patient Protection and Affordable Care Act.

(5) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) **(i)** 29 months after the date of the Qualifying Event, or **(ii)** the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

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

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a Child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under What Circumstances Can the Maximum Coverage Period be Expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Sponsor.

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

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

Must the Plan Allow Payment for COBRA Continuation Coverage to be Made in Monthly Installments? Yes. The Plan is also permitted to allow for payment at other intervals.

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

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

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be

made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1.866.444.3272.

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. OnPoint is the benefit plan of the County of Onondaga, the Plan Administrator, also called the Plan Sponsor.

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

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

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

Duties of the Plan Administrator.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes that may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

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

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

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

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

MISREPRESENTATION/FRAUD

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

REFUND DUE TO OVERPAYMENT OF BENEFITS

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

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

AMENDING AND TERMINATING THE PLAN

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

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

FEDERAL LAWS

This Plan shall be governed and construed according to Federal laws such as, but not limited to, the Public Health Service Act, as applicable, and the Health Insurance Portability and Accountability Act, as amended. Federal laws will affect the provisions of this Plan only when directed at this type of self-funded health Plan for Plan Sponsors regulated by the laws. You may seek assistance or information about your rights under this plan by contacting the closest Employee Benefits Security Administration (EBSA), U.S. Department of Labor shown in your local phone directory or contact the Division of Technical Assistance and Inquiries, Employee Benefits

Security Administration, U. S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

HIPAA COMPLIANCE

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

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

PLAN NAME: Onondaga County Point of Service Health & Wellness Plan

TAX ID NUMBER: 15-6000461

PLAN EFFECTIVE DATE: January 1, 1998

RESTATEMENT EFFECTIVE DATE: January 1, 2015

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION: Onondaga County
John H. Mulroy Civic Center
421 Montgomery Street, 15th Floor
Syracuse, New York 13202
315.435.3498

PLAN ADMINISTRATOR: Onondaga County

CLAIMS ADMINISTRATOR:

Health: POMCO
2425 James Street
Syracuse, New York 13206
1.866.543.0277

Prescription: ProAct
1230 US Route 11
Gouverneur, NY 13642
1.877.622.8440