CITY OF ROME GROUP HEALTH PLAN

MEDICARE RETIREE OPTION

Adoption Date: January 1, 2011

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INTRODUCTION

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

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

This booklet is not an employment contract or an offer to enter into an employment contract. Plan benefits and rights to Plan benefits will never vest. Retirement does not in any manner confer upon a Covered Family Member any right to continued benefits under this Plan. This Plan is not subject to ERISA. For more information regarding your rights as a participant under this Plan, see the section entitled Statement of Rights.

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

The Medicare Supplement Plan for Retirees is intended to supplement Medicare benefits only. You must be enrolled for both Part A and Part B of Medicare in order to be eligible for benefits under the Medicare Supplement Plan for Retirees.

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

City of Rome Medicare Supplement Plan for Eligible Retirees

All claims must be filed within 24 months from the date the claim is incurred or the claim will be denied.

The following chart illustrates how the City of Rome Medicare Benefits fill all the major benefit gaps in Medicare Parts A and B

SERVICE:	BENEFIT:	MEDICARE PAYS:	EBS-RMSCO PAYS:	YOU PAY:
Part A Hospitalization Semiprivate room and board, general nursing, miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia, and rehabilitation services	First 60 days	All but Part A deductible	Part A deductible	Nothing
	61st – 90th day	All but Medicare co-payment amount for each day	Medicare co-payment amount for each day	Nothing
	91st – 150th day	All but Medicare co-payment amount for each day	Medicare co-payment amount for each day	Nothing
	Beyond 150 days	Nothing	365 additional days during your lifetime	Nothing
Post-Hospital Skilled Nursing Care In a facility approved by Medicare, you must have been in a hospital for at least three consecutive days and enter the facility within 30 days after the hospital charge	First 20 days	100% of costs	Nothing	Nothing
	Additional days	All but Medicare co-payment amount for each day	Medicare co-payment amount for each day	Nothing
	Beyond 100 days	Nothing	Nothing	All
Blood		100% of costs except non-replacement fees (blood deductible) for first three points in each benefit period	Reasonable cost of first three (3) pints in each calendar year	Nothing
Parts A & B Home Health Care Services		Intermittent skilled nursing care and services in the home (daily skilled nursing care for up to 21 days or longer in some areas)	20% co-payment for durable medical equipment covered under Part B	Nothing
Part B Professional Services Expenses	Doctor/Professional Provider services inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy, and ambulance	80% of Medicare's reasonable charge after an annual Part B deductible	The deductible plus 20% of Medicare's reasonable charge	Balance, if any, of provider charge over Medicare approved amount

SERVICE:	BENEFIT:	MEDICARE PAYS:	EBS-RMSCO PAYS:	YOU PAY:
Blood		80% of costs except non-replacement fees (blood deductible) for first three points in each benefit period	Reasonable cost of first three (3) pints in each calendar year	Nothing

City of Rome Medicare Supplement Plan for Eligible Retirees (continued)

- If hospice benefits under the Federal Medicare program are exhausted, additional benefits are available under this program.

- When you are hospitalized outside the United States in a short-term acute care general hospital which would qualify under Federal Medicare if it were within the United States, we will pay for up to 90 days in a benefit period.

Note: Your best source of information about Medicare is your local Social Security office and federal publications, such as the “Medicare Handbook.”

EXTENDED HEALTH CARE COVERAGE

(The following benefits are available only after the benefits in the Medicare Supplement Plan have been exhausted.)

MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

		The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	**IMPORTANT PROVISIONS**	**BENEFIT**
DEDUCTIBLE	Per calendar year (Carryover applies)	$100 Individual
OUT-OF-POCKET MAXIMUM	Does not include the deductible. (Carryover does not apply)	$400 Individual per Lifetime
LIFETIME MAXIMUM		$1,000,000

		The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	**IMPORTANT PROVISIONS**	**IN-NETWORK PROVIDER**
AMBULANCE		80%
BLOOD AND BLOOD PRODUCTS		80%
CHIROPRACTOR		80%
DENTAL CARE COVERED UNDER MEDICAL PLAN -Accidental Injury to Teeth	Treatment must be complete within 12 months of the date of the Injury.	80%
DENTAL SERVICES	Includes oral exams, x-ray and lab tests; cleanings, fluoride applications, sealants; space maintainers fillings; extractions; endodontics; periodontics; crowns; prosthetic services including dentures and bridges; and oral surgery.	80% of the Reasonable and Customary (R&C) amount or the Preferred Provider Reimbursement Schedule amount to a maximum of $1,250 per calendar year
DIABETIC TREATMENT -Supplies and Equipment		100%, not subject to deductible
DIAGNOSTIC X-RAYS AND IMAGING TESTS -Independent Facility -Outpatient Hospital -Physician's Office		80% 80% 80%
HIGH TECH IMAGING ***(SUCH AS MRI, MRA, PET AND CAT SCANS)***		80%
DIALYSIS OR HEMODIALYSIS -Outpatient Hospital -Any Other Place of Service		80% 80%
DURABLE MEDICAL EQUIPMENT (DME) ***Including, but not limited to:*** -Durable Medical Equipment -Disposable Medical Supplies -Prosthetics (Internal) -Prosthetics (External) -Orthotics (Braces)		80% 80% 80% 80% 80%

		The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	**IMPORTANT PROVISIONS**	**IN-NETWORK PROVIDER**
HOSPITAL FACILITY Inpatient Hospital	Unlimited days	80% An additional $10 per day will be allowed when confined in a private room.
LABORATORY -Independent Facility -Outpatient Hospital -Physician's Office		 80% 80% 80%
OCCUPATIONAL THERAPY -Outpatient Hospital -Any Other Place of Service		 80% 80%
ORGAN TRANSPLANTS Guidelines apply – Refer to your Summary Plan Description for more information on this benefit		80%
PHYSICAL THERAPY -Outpatient Hospital -Any Other Place of Service		 80% 80%
PHYSICIAN -Inpatient -Office -Home Consultation (Specialist) -Inpatient -Outpatient -Office Second Medical Opinion		 80% 80% 80% 80% 80% 80% 80%

		The Allowable Expense is limited to the Reasonable and Customary (R&C) amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	**IMPORTANT PROVISIONS**	**IN-NETWORK PROVIDER**
PREVENTATIVE/WELL CARE		
-Bone Density Testing		80%
-GYN Office Visit	One per calendar year	80%
-PAP Smear	One per calendar year	80%
-Mammogram	One baseline for women between age 35 and 40; one per calendar year for women 40 years and older; covered for women at any age with a prior history of breast cancer, have a family history of breast cancer or it is recommended by the attending physician.	80%
-Prostate-Specific Antigen (PSA)	One per calendar year for men over age 40 with family history or other risk factors; one per year for men age 50 and over; one exam covered at any age for men who have a prior history of prostate cancer. Includes digital exam.	80%
PRESCRIPTION DRUGS		80%
PRIVATE DUTY NURSING	Covered inpatient and home for up to 750 hours per Covered Family Member per calendar year.	80%
RADIATION THERAPY		
-Outpatient Hospital		80%
-Any Other Place of Service		80%
SPEECH THERAPY		
-Outpatient Hospital		80%
-Any Other Place of Service		80%
SUBSTANCE ABUSE TREATMENT		
-Outpatient/Office		80%

VISION CARE EXPENSE BENEFIT

TYPE OF SERVICE	IMPORTANT PROVISIONS	The Deductible applies to all services prior to benefit payment, except where noted. BENEFIT
EYE EXAMINATION	One exam per calendar year	Plan pays a maximum of $35 per examination.
EYEGLASS LENSES	One pair per calendar year*	
-Single vision		Plan pays a maximum of $18 per calendar year
-Bifocal (Single)		Plan pays a maximum of $33 per calendar year
(Double)		Plan pays a maximum of $63 per calendar year
-Trifocal		Plan pays a maximum of $48 per calendar year
-Lenticular		Plan pays a maximum of $140 per calendar year
EYEGLASS FRAMES	One pair every two calendar years	Plan pays a maximum of $15 per pair.
CONTACT LENSES	One allowance per calendar year*	Plan pays a maximum of $140 per calendar year.
* Per each calendar year, the Plan covers charges for eye glass lenses *or* contact lenses, not both. The Plan does not cover sunglasses, even if ordered by your Optometrist or Ophthalmologist.		

Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.

DEFINITIONS

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

Adoption Date means the January 1, 2011 restatement effective date.

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

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

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

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

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

Biologically Based Mental Illness means a mental, nervous, or emotional disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Under Timothy's Law, the following disorders satisfy the definition of biologically based mental illness: Schizophrenia/psychotic disorders, major depression, bipolar disorder.

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

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

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

(1) Your marriage, divorce, legal separation or annulment.
(2) Death of your spouse or other dependent.
(3) A change in the number of your qualifying dependents or their eligibility, including:

    (A) Birth of your child.
    (B) Adoption or placement for adoption of a child with you.
    (C) Your child satisfies, or ceases to satisfy the eligibility requirements.

(4) You or your Dependent have a change in employment status that causes a gain or loss of coverage under this Plan or another employer plan providing the same benefits, including:

    (A) Commencement or termination of employment, strike or lockout.
    (B) Commencement or return from an unpaid leave of absence.
    (C) An eligibility status change for the Plan.
    (D) A change in worksite that affects eligibility for coverage.
    (E) Any other employment status change permitted by the Internal Revenue Service.

(5) A change in residence that affects eligibility for coverage.
(6) You or your Dependent's health coverage changes (you gain or lose eligibility) due to a significant change in the scope or cost of your health coverage.
(7) A significant change in health coverage due to your spouse's employment.
(8) Your Dependent makes a change under another plan that is either consistent with one of the above events or made during the normal election period of the other plan.
(9) Any other change that is permitted under Federal law and allowed by the Plan.

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

Child means your biological Child, stepchild, legally adopted Child, or Child for whom you or your spouse are the legal guardian until they turn age 26. Proof of legal guardianship must be submitted to the Plan Administrator when requested.

A legally adopted Child must have been placed for adoption (whether or not the adoption is final) before the Child's 18th birthday in order to be Eligible under this Plan. Child also means any other individual for whom you are obligated to provide coverage under the terms of any Qualified Medical Child Support Order.

Coverage for any Child who is mentally or physically handicapped, mentally ill, or developmentally disabled, as determined by the Social Security Administration, and incapable of self-sustaining employment can be continued after they reach the limiting age of the Plan if their disability began prior to such age. The disabled Child must be dependent on you for financial support, as defined by the Internal Revenue Code and the Covered Employee must declare the Child as an income tax deduction. The Employee must provide proof that the Child is incapable of self-sustaining employment within 31 days of the Child reaching the limiting age of the Plan.

The disabled Child must meet the above support requirements and submit proof of disability to the Claim Administrator upon request.

Children With Serious Emotional Disturbances is defined as those Children under the age of 18 who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and one or more of the following: serious suicidal symptoms or other life threatening self-destructive behaviors; significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); behavior caused by emotional disturbances that place the child at risk of causing personal injury or significant property damage, or behavior caused by emotional disturbance that placed the Child at substantial risk of removal from the household.

Claim Administrator means EBS-RMSCO, Inc.

Claim Determination Period means Plan benefits will be determined on a calendar year basis.

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

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

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

Coinsurance Maximum or **Out-of-Pocket Maximum** means the total amount of Coinsurance that a Covered Family Member must pay in a calendar year as indicated on the Coverage Summary.

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

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

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

(8) If not an integral part of a Hospital, it must have a written agreement with one or more Hospitals to provide for the transfer of patients and medical information between the Hospital and the Convalescent/Skilled Nursing Facility, and

(9) With respect to Covered Family Members who are entitled to Medicare, it is an approved provider of services under Medicare, and

(10) It is accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or another internationally recognized accreditation agency.

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

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

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

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

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

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

(1) Is furnished mainly to help a person in the activities of daily living, and

(2) Can be furnished by someone with no professional health care training or skills.

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

Dependent means your Child or legal spouse from whom you are not legally divorced or a legal spouse of an Employee whose marriage has not been legally annulled. A common law spouse is not recognized as your legal spouse under the Plan, even if it is recognized in the State or municipality of residence.

Doctor means a physician; osteopath; dentist; podiatrist; optometrist; psychiatrist; registered psychologist; chiropractor; licensed physical therapist; a certified social worker recognized by

the New York Bureau of Social Work under the six year post degree criteria; licensed nurse-midwife practicing as required by New York law; and other health care professionals who are licenses to provide the services covered under the Plan. A Doctor must be operating within the scope of his license to provide Medically Necessary Covered Services.

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

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

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

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

Employee means an individual who works for the City of Rome who works the minimum number of hours required by the Employer or by their union contract and whose income is reported for tax purposes using a W-2 form and. An Employee must also meet the eligibility requirements described in the section entitled “Eligibility and Participation”.

Employer or **City** means the City of Rome and any affiliate companies and subsidiaries that adopt this Plan.

Enrollment Date means, for the purposes of complying with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as it pertains to any applicable Pre-Existing Condition, the Covered Family Member’s Participation Effective Date or, if there is a waiting period for coverage, the first day of such waiting period (the date employment begins). An Enrollment Date for a Family Member who late enrolls under the Plan or who is eligible for a Special Enrollment Period shall be the Participation Effective Date.

Experimental or **Investigative** means services, supplies, care and treatment that do not constitute accepted medical practice. When determining whether or not a procedure is Experimental or Investigative, the Plan will take into consideration appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

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

background investigation of the claim and the proposed treatment. The Plan will be guided by the following principles:

(1) The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, except where the laws of the state mandate coverage for any drug not approved by the FDA but recognized as appropriate treatment for a particular type of cancer by an established reference such as the AMA Drug Evaluations, or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additionally, the following institution will qualify under this definition:

(7) A licensed birthing center that:

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

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

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

Maintenance Care means continuing care that seeks to prevent disease, promote health, prolong life, and enhance the quality of life. There is also no evidence of improvement of the condition being treated, and the schedule of visits for care is not consistent with an acute pattern of treatment (e.g. every 2 to 4 weeks, or less frequently).

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

Medical Services Team means an organization engaged by the Plan Administrator and/or the Claim Administrator for the purposes of providing utilization review and medical case

management services for the Plan. In addition, the Medical Services Team will provide services as may be determined by the Plan Administrator or Claim Administrator.

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

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

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

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

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

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

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

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

Open Enrollment Period means the time period(s) of each calendar year during which Eligible Retirees and/or their Dependent(s) may enroll in or change their election in the Plan.

Other Plan means arrangements of group insurance or group subscriber contracts (other than this Plan) through HMOs, Medicare or other government benefits, portions of group long-term care contracts, i.e. skilled nursing care, and other prepayment, group practice, and individual practice plans. Group-type contracts, through membership in a particular organization or group,

which are not available to the general public, group hospital indemnity benefits in excess of $200 per day, and group or individual automobile “no-fault”, traditional “fault”, or tort type policies are also considered other plans. All provide medical, dental, or optical benefits or services on an insured, self-insured or an uninsured basis.

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

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

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

Plan means the City of Rome Group Health Plan – Medicare Retiree Option adopted and maintained pursuant to this document which sets forth the rights and obligations of the persons entitled to benefits under the Plan and the procedures by which Plan fiduciaries may be identified.

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

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

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

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

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

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

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

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

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

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

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

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

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

Reasonable and Customary means the smaller of:

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

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

(1) The nature and severity of the condition, and
(2) The complexity involved, and
(3) The degree of professional skill required, and
(4) Any unusual circumstances which require additional time, skills or experience.

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

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

Retiree means an Employee who retires directly from Active Service from the City of Rome and as defined in the proper union contract, as applicable.

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

Skilled Care means a service which we determine is furnished by or under the direct supervision of licensed medical personnel to assure the safety of the patient and achieve the medically desired results as defined by Medicare guidelines. A service is not considered a skilled service merely because it is performed or supervised by licensed medical personnel. However, it is a service that cannot be safely and adequately self-administered or performed by the average non-medical person without the supervision of such personnel.

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

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

The plan will also permit Employees and Dependents who are “Eligible but not enrolled” in the Plan a 60-day period to enroll in this Plan in the event of one of the following two circumstances:

(1) The employee’s or dependent’s Medicaid or the Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
(2) The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

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

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

Surviving Spouse/Dependent means a spouse or Dependent Child who is a Covered Dependent under this Plan on the date of an Employee's death and as defined in the Employee or Retiree's union contract.

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

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

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

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

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

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

DETAILED DESCRIPTION OF BENEFITS

The Medicare Supplement Plan for Retirees is intended to supplement Medicare benefits only. You must be enrolled for both Part A and Part B of Medicare in order to be eligible for benefits. Any service or supply that is not covered under Medicare is not covered under the Medicare Supplement Plan for Retirees.

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

The Plan will pay benefits for Medically Necessary expenses subject to deductibles, coinsurance, maximums, and any limitations, as shown in the Schedule of Benefits for Retirees and elsewhere in this document. Under no circumstances will this Plan make any payments for the difference between the Medicare allowed amount and the actual charge for the service. Any service not covered by Medicare will not be covered under the Medicare Supplement Plan for Retirees, except where noted. Covered services include:

(1) **MEDICARE PART A DEDUCTIBLES AND COPAYMENTS**: When you have been hospitalized and have received benefits under Part A of Medicare for that hospitalization, this Plan will pay the following deductibles and copayments, which are left as balances after Medicare has made its payment:

(A) Medicare's Part A deductible in each benefit period;
(B) The copayment amount for the 61st through 90th day of each benefit period;
(C) The copayment amount for the Medicare 60 lifetime reserve Hospital days.

A benefit period begins when you enter a Hospital. Successive stays in one or more Hospital or skilled nursing facility count as one benefit period unless 60 days or more elapse between the day of discharge and the next admission. When you enter a Hospital after 60 days have elapsed since the last discharge from the Hospital or skilled nursing facility, a new benefit period starts.

The Medicare Part A deductible amount usually increases each year. The Plan will pay the deductible even though it increases.

(2) **ADDITIONAL HOSPITAL DAYS**: During a benefit period, if you have used all your Medicare Hospital days, including your Medicare lifetime reserve days, then the Plan will pay for additional days of inpatient Hospital care in the same benefit period. The Plan will only pay for such additional days if, in the Plan's judgment, it is Medically Necessary for you to be hospitalized. The Plan will not pay for more than 365 of such additional days in your lifetime. The Plan's payment for each such additional day of inpatient care will be limited to:

(A) Those kind of expenses that would have been paid under Medicare, and
(B) Only when you are hospitalized in a short term acute care general Hospital that either qualifies under Medicare or is accredited by the Joint Commission on Accreditation of Health Care Organizations, and
(C) Only when Medicare would have made payment if you had not used all your Medicare days.

(3) **BLOOD DEDUCTIBLE UNDER MEDICARE**: The Plan will pay for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) under Part A or Part B of Medicare each year, unless the blood is replaced in accordance with federal regulations.

(4) **POST-HOSPITAL SKILLED NURSING FACILITY CARE**: When you are confined in a skilled nursing facility following hospitalization and you receive benefits under Part A of Medicare for that confinement, this Plan will pay the copayment amount from the 21st day through the 100th day in each benefit period.

The copayment amount for skilled nursing facility care under Part A of Medicare usually increases each year. The Plan will pay the copayment even though it increases.

(5) **PART B DEDUCTIBLE AND COINSURANCE**: When Medicare pays for a service covered under Part B of Medicare, the Plan will pay the deductible and coinsurance, if any, based on Medicare's allowed amount. If Medicare pays 100% of the allowed amount covered under Part B or Medicare pays nothing for any service, the service will not be reimbursed under this Plan. Under no circumstances will this Plan make any payments for the difference between the Medicare allowed amount and the actual charge for the service.

(6) **MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY**: The Plan will pay for Emergency care in a foreign country under the following terms and conditions:

(A) Emergency means a condition manifesting itself with acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to pregnant women, the health of the woman's unborn Child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.
(B) Emergency care coverage is limited to those expenses for Medically Necessary Emergency Hospital, physician and medical care in a foreign country which would have been covered under Medicare if the participant or dependent had received the care within the United States.
(C) The Emergency care must begin within the first 60 consecutive days of each trip outside the United States.

(D) Payments for Emergency care under this provision are limited as described in the Schedule of Benefits.

(E) If Medicare pays for any service that is rendered outside the United States, this Plan will only base its payment on the balance left over after Medicare has made its payment.

EXTENDED HEALTH CARE BENEFITS

The services described in this subsection are covered only after you have exhausted the benefits available in the previous subsections. This subsection may also cover some benefits which are not provided in the previous subsections.

The Plan will provide benefits under this subsection only when it is determined that the following services are Medically Necessary for the treatment or care of your condition, Illness or Injury.

(1) **Inpatient Hospital Benefits**. Additional inpatient Hospital days are covered if you have used all the inpatient Hospital days available in the previous subsections and still must remain in the Hospital; or you have been hospitalized again before 60 days have elapsed between periods of hospitalization. The Plan inpatient care as described in the Coverage Summary.

For inpatient stays not covered in the previous subsections the Plan will cover most of the services provided by the Hospital including semi-private room charges. If you are in a private room, the Plan will pay an additional $10 per day, even if it is not Medically Necessary for you to be in a private room. The services must be:

(A) Available in the Hospital in which you are a patient;
(B) Performed by an employee of the Hospital; and
(C) Billed by, and payable to the Hospital.

(2) **Doctor's Services**. The Plan will cover services you receive from a Doctor for the treatment of an Illness or an Injury. The Plan will only cover services of those Doctors that New York State legally recognizes and bills you for services. These services may be provided in a Hospital; a Skilled Nursing Facility; your home; or the Doctor's office.

(3) **Dental Services**. The Plan will pay for dental services rendered by a Doctor when required because of an accidental Injury to sound natural teeth if the accident occurred when you were covered under the Plan. The dental service must be performed within 12 months of the accident.

The Plan also covers dental care and treatment including appliances and prosthetic devices. Coverage will also include the following services: oral exams, x-ray and lab tests in connection with examinations; cleanings, fluoride applications, sealants; space maintainers fillings; extractions; endodontics; periodontics; crowns; prosthetic services including dentures and bridges; and oral surgery for preparation of an alveolar ridge, treatment of a fracture, tooth replantation, biopsy of oral tissue, and removal and restoration of gums. Dental

oral surgery benefits include the necessary general anesthesia administered by a dentist or physician.

Dental Services Limitations and Exclusions: The Plan only covers one prosthetic appliance in any five year period. The Plan also excludes the replacement of any existing appliance, denture or bridge unless it is determined, in the Plan's sole judgment, that it is not satisfactory or it cannot be made serviceable and at least five years have elapsed before its replacement. The Plan also does not cover services, appliances or restorations necessary to increase vertical dimension, or restore or correct occlusion. Also excluded are gold restorations and services or appliances for orthodontic purposes.

(4) **Private Duty Nursing Services**. The Plan covers services of a private duty registered nurse or licensed practical nurse in a Hospital. Outside of a Hospital, the Plan covers services of a private duty registered nurse. The nurse must not be a relative or a person living in your home. A Doctor must order the services. The Plan alone will determine if private duty nursing services are Medically Necessary for treatment of your medical condition. The nature of your Illness or condition must show that nursing care can only be provided by a person with the education and skills of a nurse. The Plan will not cover services which consist mainly of providing assistance with the activities of daily living, nor with the Plan cover the services of a private duty nurse if you are receiving home care services. Benefits will be limited as described in the Coverage Summary.

(5) **Ambulance Services**. The Plan covers local ground transportation by an ambulance service by means of a specially designed vehicle used only for transporting the sick or injured. The service must be for an inpatient admission or for Emergency outpatient care with transportation to the nearest Hospital. If the nearest Hospital is not able to treat the disability or condition, the Plan will cover ambulance service to the nearest Hospital which can. The Plan also covers ambulance service from the Hospital to the patient's home if it has been ordered by a Doctor.

(6) **Chemotherapy**. The Plan covers services and medication used for non-experimental cancer chemotherapy and cancer hormone therapy.

(7) **Diagnostic Services**. The Plan covers diagnostic tests or procedures which are performed because of specific symptoms and are directed toward determining a definite condition. We will only cover such services if they are ordered by and reported to your Doctor. These services include, but are not limited to:

(A) X-rays and other radiology services;
(B) Laboratory and pathology tests;
(C) Cardiographic, encephalographic and radioisotope tests.

(8) **Therapy Services**. The Plan covers physical and occupational; radiation; and speech therapy under the following conditions:

(A) The therapy is ordered by a physician.
(B) The therapy is provided by skilled medical personnel licensed to provide the therapy.

(C) Therapy services are limited to treatment(s) for conditions that are subject to significant clinical improvement within a two-month period of time, and not solely to prevent further deterioration or maintain one's health status. The therapy must be related to treatment of a specific Illness or Injury.

(D) The therapist must submit a treatment plan for approval when you are expected to require more than 10 therapy treatment sessions in a calendar year. The plan must be submitted within 10 days after you begin treatment. If a treatment plan is not submitted within 10 days, or the Plan does not approve the treatment plan, the therapy you receive will not be covered.

(E) The speech therapy is provided for the correction of speech impairment resulting from disease, trauma, congenital anomaly or previous therapeutic processes.

(9) **Vision Care**. The Plan covers routine vision care charges, including eye exams and refractions, lenses, frames and contact lenses as described in the Coverage Summary.

The Plan will cover lenses or frames prescribed and ordered prior to the date you are no longer covered under the Plan even if they are not received until after your coverage under the Plan terminates.

(10) **Blood Products**. The Plan covers blood transfusions including the cost of blood; blood plasma; and blood processing charges only if the blood products are unavailable free of charge in the local area.

(11) **Durable Medical Equipment**. The Plan covers the rental or purchase or Durable Medical Equipment. The Plan will decide whether the equipment should be rented or purchased. Your Doctor must order the use of the equipment for the treatment or care of your condition.

Durable Medical Equipment does not include, for example, hearing aids, shoes, or other articles of clothing, personal hygiene and convenience items such as air conditioners, humidifiers or physical fitness equipment.

The Plan will cover the necessary repairs and maintenance or purchased equipment, unless they are covered by a warranty or purchase agreement. The Plan does not cover delivery charges.

(12) **Prosthetic Devices**. The Plan covers prosthetic devices, necessary adjustments, and their replacements. They must be ordered by your Doctor to relieve or correct a condition caused by an Injury or Illness.

Examples of prosthetic devices are braces and artificial arms, legs, and eyes used to replace non-functioning or absent parts of the body. Such devices, for example, do not include hearing aids, cosmetic devices, weights, dentures, caps, crowns, implanted teeth, or other devices used in connection with the teeth. Eyeglasses are not considered a prosthetic device, but are included in the vision care benefit. Implanted cataract lenses are covered when they perform the function of the human lens and are medically required because of intraocular surgery.

(13) **Medical Supplies**. The Plan covers medical supplies for your use outside the Hospital. These supplies are limited to the following: ostomy bags and supplies required for their use; catheters; syringes and needles necessary for such conditions as diabetes; dressings when the Plan determines a substantial quantity is necessary for the treatment of such conditions as cancer, diabetic ulcers, and burns; casts and splints; and oxygen. Your Doctor must order the use of these supplies.

(14) **Prescription Drugs**. The Plan covers medicines for which the law requires a prescription and injectable insulin. The medicine or insulin must be prescribed by your Doctor for use outside a Hospital or Skilled Nursing Facility which does not have its own pharmacy. The prescription drugs must be approved for general use by the Food and Drug Administration and dispensed by a licensed pharmacy. The prescription drug must be Medically Necessary.

(15) **Human Organ or Tissue Transplant Donor Expenses**. If and individual who is not Covered under this Plan donates a human organ or tissue which is transplanted to you, the donor will receive benefits under this Plan even if the donor is not otherwise Covered under this Plan. However, the Plan will not cover the organ or tissue donation if the donor is covered under a health benefit plan which covers the services and care required to make an organ donation. The Plan will only cover those benefits which are not provided or unavailable to the donor from any other source. The amounts payable to or on behalf of the donor will be charged against your Lifetime Maximum under the Plan.

(16) **Chiropractic Services**. The Plan covers Medically Necessary detection or correction by manual or mechanical means of structural imbalance, distortion, or sublaxation in the human body for the purposes of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or sublaxation of or in the vertebral column.

(17) **Substance Abuse Treatment (Outpatient)**. The Plan covers outpatient Substance Abuse in a facility described below for the diagnosis and treatment of alcoholism and Substance Abuse. Each visit must consist of at least one of the following: individual or group alcoholism or Substance Abuse counseling; active therapy; and diagnostic evaluations by a Doctor to determine the nature and extent of your illness and disability. The Plan does not pay for visits which consist primarily of participation in programs of a social; recreational; or companionship nature.

The services must be provided by an employee of the facility. The Plan will not make any payments to a person who provides any of the Covered Services, nor will it make payments if the facility turns the payments over to the person who provided the services.

Treatment Plan: The facility where you receive treatment must submit a treatment plan for approval within 10 days after you begin treatment. If a treatment plan is not submitted within 10 days, or if the Plan does not approve the treatment plan, payment will not be made for any visits that take place more than 10 days after you begin treatment.

Covered Facilities: The Plan covers treatment in New York State only if the facility where the outpatient visits take place is certified by the State as medically supervised to provide an ambulatory Substance Abuse program. If you receive treatment outside of New York State, the facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations to provide an alcohol or Substance Abuse treatment program.

The Plan will make payments even if the facility is owned, operated or maintained by a State government or any local government, even though this Plan otherwise excludes coverage in government Hospitals. However, the facility must be certified or accredited as described above, and the Plan will not cover such services if the facility would not have charged you if you were not covered under the Plan or any other insurance.

PLAN EXCLUSIONS

In addition to certain exclusions and limitations already described previously, the Plan does not pay when any of the following apply to you:

(1) **Any Other Employment.** The Plan does not cover any Sickness, Injury, occupational disease or condition arising out of, or in the course of, any employment for wage, profit, intent of profit, or self-employment, or for which the Covered Family Member is or was entitled to receive workers' compensation benefits.

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

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

(2) **Cosmetic Procedures.** The Plan does not cover cosmetic surgery or procedures, unless it qualifies as Reconstructive Surgery as defined, including human or artificial hair transplants or any drug, prescription or otherwise, used to eliminate baldness.

(3) **Government Hospitals (VA Hospitals).** The Plan does not cover services or supplies furnished to the Covered Family Member in a Hospital owned or operated by the United States Government or any other government or in a facility maintained by the Veteran's Administration unless there is a legal obligation to pay

such charges without regard to the existence of any coverage.

(4) **Ineligibility.** The Plan does not cover charges that are incurred before a participant becomes Covered by the Plan, after the Covered Family Member's coverage ended, or after the Plan has terminated.

(5) **Not Legally Required to Pay.** The Plan does not cover charges which would not have been made if no coverage had existed or for which the Covered Family Member is not legally required to pay, or payment is unlawful in the jurisdiction where the person resides at the time expenses are incurred.

(6) **Physical Exams.** The Plan does not cover routine exams and immunizations for the sole purpose of employment, school, camp, travel to a foreign country or extracurricular activities.

(7) **Public or Government Program Reimbursements.** The Plan does not cover charges to the extent that the Covered Family Member is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any public or government program or applicable law, other than the program of Medical Assistance for Needy Persons (Medicaid).

(8) **Routine Physical Examinations/Services.** The Plan does not cover routine exams and services rendered in a Hospital during an inpatient confinement (except charges for routine nursery care of newborn Child), unless otherwise specified in the Plan.

(9) **Services of a Relative or Household Member.** The Plan does not cover services provided by your immediate family (the patient's Spouse, children, brother, sisters, parent of Spouse or other person residing with the patient).

DETERMINATION OF BENEFITS

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

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

The payment for any claim for a Covered Service is subject to clinical edits. The Plan will take into consideration appropriate health care practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the health care community or government oversight agencies. All services or procedures, unless specifically stated otherwise, are subject to Medical Necessity review. The Claim Administrator will also have the right to make Benefit Determinations based on the Claim Administrator's

Policies and Procedures Manual developed in conjunction with the above standards of practice, and health care professionals.

CLAIM DETERMINATION PROCEDURE

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

(1) In-Network Claim Determination Procedure: When a Covered Service is received from a member of this Plan's Preferred Provider Network, the claim will be submitted by the Provider and the Claim Administrator will pay the Provider directly. Network Providers agree to accept reimbursement using the Preferred Provider Reimbursement Schedule. The Covered Family Member may be required to make a Copayment, Coinsurance payment, or deductible payment at the time a service is received.

(2) Out-of-Network Claim Determination Procedure: When a Covered Service is received from an out-of-network Provider, proof of the service must be submitted to the Claim Administrator using the out-of-network claim determination procedure described in the next subsection. When the Provider or the Covered Family Member submits a claim, the Claim Administrator will determine the amount of any reimbursement payable.

(3) Urgent Care Claims: An expedited claim determination procedure will be followed whenever the Medical Services Team receives any communication from a Provider regarding an Urgent Care Claim. An Urgent Care Claim includes medical care or treatment that, when administered expeditiously would avoid serious jeopardy to the Covered Family Member's life, health, and ability to regain maximum function, or would avoid subjecting the Covered Family Member to severe pain that cannot be managed without the proposed care.

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

When a claim involving Urgent Care receives an Adverse Benefit Determination, an expedited appeal process is available. When an Urgent Care Claim is denied, in whole or in part, the Determination of Benefits for any appeal of the Adverse Benefit Determination will be made within the 72 hours following receipt of the appeal. No action at law or in equity will be brought to recover on the Plan until 72 hours following the filing of an appeal involving Urgent Care. No action will be brought at all unless brought within 24 months of the Adverse Benefit Determination.

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

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

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

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

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

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

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

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

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

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

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

ADVERSE DETERMINATION

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

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

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

(1) Specific reasons for the denial, and
(2) Specific references to pertinent Plan provisions on which the denial is based, and
(3) A description of any additional material or information necessary to complete the claim, and an explanation of why such material is necessary, and
(4) An explanation of further appeals procedures, and
(5) A statement that a failure to submit a written request for review within 180 days after the receipt of the denial will render the Adverse Determination final.
(6) A description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of the Covered Family Member’s right to

bring a civil action under the law following an Adverse Determination on review, and

(7) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, either such information; or a statement that such information was relied upon in making the Adverse Determination will be provided free of charge to the Covered Family Member upon request, and

(8) If the Adverse Determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Covered Family Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request, and

(9) In the case of an Adverse Determination concerning a claim involving Urgent Care, a description of the expedited review process applicable to such claims.

CLAIM APPEALS

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

(1) Write to the Claim Administrator within 180 calendar days of receiving the Adverse Determination (claims involving Urgent Care receive the expedited appeal process already described) and request an appeal. You may submit written comments, documents, records, and any other pertinent information relating to the claim. Copies of all information relevant to the claim for benefits will be available upon request. This information will be available without regard to whether or not the information was considered or relied upon in making the Adverse Determination. The review the Claim Administrator completes:

   (A) Will take into account all submitted information, without regard to whether or not the information was submitted or considered in the initial Benefit Determination, and

   (B) Will not provide deference to the initial determination, and

   (C) Will not be decided by the individual who made the initial Adverse Determination or that individual's subordinate, and

   (D) Will include a consultation with an independent health care professional with appropriate training and experience in the field of medicine if the review is being done to determine Medical Necessity.

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

(2) Within 30 calendar days of receiving an appeal (15 days for claims involving a Pre-Service Claim), the Medical Services Team will review the claim and provide a written determination on the appeal. The written decision will specify the

reasons for the decision and will give specific references to the Plan provisions on which it is based:

(A) Specific reasons for the denial, and
(B) Specific references to pertinent Plan provisions on which the denial is based, and
(C) A description of any additional material or information necessary to complete the claim, and an explanation of why such material is necessary, and
(D) An explanation of further appeals procedures, and
(E) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Covered Family Member's right to bring a civil action under the law following an Adverse Determination on review, and
(F) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, either such information; or a statement that such information was relied upon in making the Adverse Determination will be provided free of charge to the Covered Family Member upon request. Copies of all information relevant to the appeal will be made available to the Covered Family Member upon request, and
(G) If the Adverse Determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Covered Family Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided on request by the claimant, regardless of whether the advice was relied on by the Plan.

(3) If the Medical Services Team maintains the original denial and the Covered Family Member still does not agree, the Covered Family Member has 30 calendar days to appeal to the Plan Administrator. When resubmitting the claim to the Plan Administrator, include correspondence received from the Claim Administrator and any other information that may be appropriate.

(4) Within 30 calendar days of filing the appeal with the Plan Administrator (15 days for claims involving a Pre-Service Claim), the Covered Family Member will receive a written decision. The Plan Administrator will either authorize the Claim Administrator to pay the claim or maintain the denial. The written explanation of the Plan Administrator's decision will cite the specific Plan provisions upon which the decision is based. The decision of the Plan Administrator is final.

(5) No action at law or in equity will be brought to recover on the Plan until after proof of loss for a non-Urgent Care Claim has been filed with the Claim Administrator and the appeal process described above has been completed. No action will be brought at all unless brought within 24 months of the time within which proof of loss is required.

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

RESPONSIBILITIES OF THE PLAN ADMINISTRATOR

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

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

The named fiduciaries shall have separate authority to control and manage the operation and administration of the Plan. Every fiduciary and other person who handles funds or other property of this Plan shall be bonded in accordance with the law.

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

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

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

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

(10) Receive all disclosures required of fiduciaries and other service providers under any federal or state law.
(11) Ensure continuing compliance with the HIPAA Privacy and Security Regulation and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), as they may be amended from time to time.

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

Discretion of Plan Administrator:

(1) The Plan Administrator shall have the absolute authority and discretion to construe any uncertain or disputed term or provision in the Plan. This includes, but is not limited to, the following:

(A) Determining whether an individual is Eligible for benefits under this Plan, and
(B) Determining the amount of benefits, if any, an individual is entitled to under this Plan, and
(C) Interpreting all of the provisions of this Plan, and
(D) Interpreting all of the terms used in this Plan.

(2) The Plan Administrator's exercise of this discretionary authority shall:

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

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

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

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

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

RESPONSIBILITIES OF THE EMPLOYER

Responsibilities of the Employer: The Employer will have the responsibility to:

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

Delegation of Responsibility: The Employer may delegate fiduciary and administrative responsibilities of the Employer to any officer or employee of the Employer. Any person to whom any responsibility is delegated may serve in more than one capacity with respect to the Plan and may be a participant in the Plan; provided, however, that no such person may exercise

fiduciary authority with respect to any matter pertaining to him individually. The Employer may also delegate to any of its officers or employees the authority to sign on behalf of the Employer all governmental reports required to be filed by the Plan Administrator.

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

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

RESPONSIBILITIES OF THE PRIVACY OFFICER

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

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

(13) Ensure continuing compliance with the HIPAA Privacy and Security Regulation and the HITECH Act, as they may be amended from time to time.

RESPONSIBILITIES OF THE CLAIM ADMINISTRATOR

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

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

(1) Interpret this Plan's provisions relating to coverage except where the Claim Administrator requests an interpretation, a claimant files an appeal with the Plan Administrator, or the Plan Administrator exercises its authority on its own volition. In said case, the Plan Administrator shall interpret the Plan and shall communicate in writing to the Claim Administrator the appropriate interpretation of the Plan.
(2) Administer this Plan's claim procedure.
(3) Pay benefits under the Plan by drawing checks against the claim account.
(4) Advise or otherwise assist the Plan Administrator or Employer in connection with the purchase of stop-loss coverage, if any, for the benefits provided under the Plan.
(5) File claims with the insurance companies, if any, who issue stop-loss insurance policies to the Employer.
(6) Perform all other responsibilities delegated to the Claim Administrator in the instrument appointing the Claim Administrator.
(7) Ensure compliance with the HIPAA Privacy and Security Regulation and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), as they may be amended from time to time, by adhering to the provisions of the Business Associate agreement.

PARTICIPATING EMPLOYERS

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

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

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

PLAN INTERPRETATION

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

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

STATEMENT OF RIGHTS

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

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

(1) Continue health coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Plan document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

(2) Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health plan, if you have creditable coverage from another health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Assistance With Your Questions: If you have any questions about your Plan, you should contact the Personnel Department. If you have any questions about this statement or about your rights under State law, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the State Insurance Department, listed in your telephone directory.

Qualified Medical Child Support Orders: The Plan provides medical benefits in accordance with the applicable requirements of any “Qualified Medical Child Support Order” as required

under law. A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a property settlement agreement) issued by either a court of competent jurisdiction or through an administrative ruling that has the force and effect of state law which:

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

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

Newborns' and Mothers' Health Protection Act: Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Administrator.

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL PLAN INFORMATION

PLAN NAME:	City of Rome Group Health Plan – Medicare Supplement Option
PLAN NUMBER:	N/A
PLAN SPONSOR:	City of Rome 198 North Washington Street Rome, NY 13440
EMPLOYER IDENTIFICATION NO.:	15-6000414
TYPE OF PLAN:	Welfare Benefit Plan for Medical, Dental, Vision and Prescription Benefits
PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS:	Diane Martin-Grande City of Rome 198 North Washington Street Rome, NY 13440 (315) 339-7668
SOURCES OF CONTRIBUTIONS:	The City of Rome and its Employees contribute funds
TYPE OF ADMINISTRATION:	Third Party Administrator: EBS-RMSCO, Inc. 115 Continuum Drive Liverpool, NY 13088
PLAN YEAR:	Plan records are kept on a Plan Year basis beginning on January 1st and ending on December 31st.
SOURCE OF FUNDING:	General corporate assets
STOP LOSS INSURANCE:	A stop loss policy is provided.
PARTICIPANT EMPLOYER:	None
PRIVACY OFFICER:	Mary Catherine Polera City of Rome 198 North Washington Street Rome, NY 13440 (315) 339-7622

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

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

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

The Plan Administrator is the "Named Fiduciary" of the Plan. The Named Fiduciary may appoint advisors and may act in more than one capacity.

This Medicare Supplement Plan was executed this ____ day of _____, 20__.

City of Rome
(Employer)

By: _____
Diane Martin-Grande

Title: _____