JEFFERSON COUNTY
HEALTH BENEFITS PROGRAM FOR
COUNTY EMPLOYEES AND DEPENDENTS

Information for Employees and Retirees
of Jefferson County Participating in the
Jefferson County Health Benefits Program

County of Jefferson

SI-154
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INTRODUCTION

This document is a description of the Jefferson County Employees Health Benefits program (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan members against certain catastrophic health expenses.

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

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

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

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

If the Plan is terminated, amended, or benefits are eliminated, the rights of covered persons are limited to covered charges incurred before termination, amendment or elimination.

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

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

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

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

This part should be read carefully since each Plan member must take action to ensure that the maximum payment levels under the Plan are paid.

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

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

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

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

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

ROLE OF THE COUNTY

The Jefferson County Insurance Department will be responsible for the administration of the Health Benefits program. Employee satisfaction can be best assured when the employee can obtain information, make complaints or obtain adjustments through his or her own County Insurance office, particularly if that can be done by personal contact.

An individual will be assigned the responsibility for the program and for providing assistance and advice to employees. Wherever there is a reference to the County Insurance Department, this individual is included in that reference.

The following functions are the responsibility of the County Insurance Department:

- Ensure that all eligible employees and retirees are properly informed of the benefits and availability of the Health Benefits program.
- Determine eligibility of employees and retirees for enrollment in the Health Benefits Program.
- Enroll employees and eligible dependents in the Health Benefits program.
- Collect the entire premium from employees who are off the payroll but still eligible to continue health benefits coverage.
- Submit transaction forms to the Third Party Administrator for new enrollment, terminations, retirement and any other changes in coverage status under the program.
- Maintain accurate and up to date files of health records.
- Distribute Statements of Coverage.
- Assist employees in completing and submitting claims, resolving claim problems and in any other aspect of their coverage with which they require assistance.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

The content in this section is not intended to constitute, or be validated as, the origin or basis for Plan eligibility requirements. The Jefferson County Insurance Department can provide details concerning your specific eligibility requirements for Plan enrollment.

Employee Eligibility Requirements. An employee of a bargaining unit must be offered the opportunity to enroll in the Plan subject to the contract language of the collectively bargained agreement in place for that employee's bargaining unit. A non-union management employee, and the employee's dependent(s), must be offered the opportunity to enroll in the Plan subject to the County Employment Policy Manual.

An employee who does not meet the eligibility requirements outlined above at the time of his/her employment may later acquire eligibility by virtue of a change in his/her employment conditions. In such cases, the date on which the employment status changes is considered the first day of eligibility for enrollment.

Note: All instances of questions of interpretation are determined by collective bargaining agreements.

A person is eligible for active or retired employee coverage according to the terms of any current applicable collective bargaining agreement or the Jefferson County Employment Policy Manual if he or she:

- Is an active employee of Jefferson County; or
- Is a retired employee of Jefferson County. Retired employees also include:
    - An employee who has at least 10 years of active service with the County and who qualifies for Social Security Disability benefits;
    - An employee granted a service-connected disability retirement, regardless of age or length of service, by a retirement or pension plan or system administered and operated by the State of New York.
    - An employee who qualifies for continued coverage as a retiree but is covered as a dependent of another employee at the time of retirement may later enroll at any time as a retiree regardless of coverage as a dependent.
    - An employee who qualifies for continued coverage as a retiree remains eligible even if he or she subsequently becomes employed and/or enrolled through another Jefferson County subdivision, except when the employee established eligibility for retiree coverage through the second employment.
    - Is in a class eligible for coverage.

A waiting period for coverage may apply. See **Effective Date**.

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

- Any terminated employee.
- Persons providing services to Jefferson County through a temporary agency or employer leasing organization.
- An independent contractor providing services to Jefferson County.

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

- **A Covered Employee's Spouse.** The term "spouse" shall mean the person recognized as the covered employee's husband or wife under the laws of the state or other jurisdiction where the covered employee lives or was married, and shall not include common law marriages. The term "spouse" shall include partners of the same sex who were legally married under the laws of the state or other jurisdiction in which they were married.

The Plan Administrator may require documentation proving a legal marital relationship. Domestic partners are not covered under this Plan.

- **A Covered Employee's Child.** An employee's "child" includes his biological child, stepchild, foster child, legally adopted child, or a child placed with the employee for adoption. An employee's child will be an eligible dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the employee or any other person.
- A covered dependent child who reaches the limiting age and is totally disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered employee for support and maintenance and unmarried.

The Plan Administrator may require, at reasonable intervals during the two years following the dependent's reaching the limiting age, subsequent proof of the child's total disability and dependency. Contact the County Insurance Department for the forms and details on how to establish eligibility for a disabled dependent child under this paragraph.

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

An employee's child is an eligible child even if the child is eligible to enroll in an employer sponsored health plan other than the group health plan of a parent of the child.

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

- **A Covered Employee's Qualified Dependents.** The term "qualified dependent" shall include any other child who permanently resides in the employee's household and receives a degree of support. This includes a grandchild or a child under legal guardianship.

To be eligible for dependent coverage under the Plan, a qualified dependent must be under the limiting age of 26 years.

If no blood or legal relationship exists, the child must be primarily dependent upon the employee or spouse. The phrase "primarily dependent upon" shall mean dependent upon the covered employee or spouse for at least 50% of the child's support and maintenance. Contact the Jefferson County Insurance Department for forms to establish financial dependence.

The Plan Administrator may require documentation proving degree of dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

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

These persons are excluded as dependents:

- Other individuals living in the covered employee's home, but who are not eligible as defined
- A domestic partner
- A divorced former spouse of the employee
- Any person who is on active duty in any military service of any country (other than a dependent child subject to the eligibility provisions of the Federal Affordable Care Act

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

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

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

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

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

FUNDING

Cost of the Plan. Jefferson County shares the cost of employee and dependent coverage under this Plan with the covered employees and retirees.

The level of any employee and/or retiree contributions is set by the Plan Administrator in accordance with any applicable collective bargaining agreement.

Waiver of Premium. Contributions for coverage may be waived for up to one year for an employee who is

totally disabled while on an authorized leave of absence without pay.

To be eligible for a waiver, the employee must:

- Be continuously totally disabled for at least three months; and
- Be on an authorized leave without pay; and
- Have maintained coverage while on leave without pay.

To apply for a waiver, the employee must obtain an “Application for Waiver of Premium” form from the County Insurance Department, complete Part A, and have the physician complete Part C. The County Insurance Department will complete Part B.

If the waiver application is approved, the waiver of contribution is effective on the later of the first day of the fourth calendar month following the occurrence of the disability or on the first day of the month following exhaustion of any accrued sick leave.

The waiver of contribution will continue during the period of total disability for up to one year but will end sooner if the County Insurance Department is notified when one of the following events occurs:

- Cessation of the total disability;
- The employee returns to paid work;
- The County approves the employee’s request to retire;
- The employee separates from service; or
- The employee’s death.

ENROLLMENT

Enrollment Requirements. An employee must enroll for Individual or Family coverage by filling out and signing an enrollment application.

If an employee does not wish to enroll in the Health Benefits program at the time of initial eligibility, he or she should complete a Declination of Health Benefits form. This form serves two purposes:

- It directs the employee’s attention to the fact that the effective date of his or her coverage may be deferred for a period of time if the employee requests coverage at a later date.
- It provides a permanent record of the fact that the employee has been advised of his or her eligibility for enrollment, and that he or she chose not to enroll at this time. Copies of the completed form shall be retained in the County Insurance office.

Enrollment Requirements for New Dependents. A newly acquired dependent spouse or child, including a newborn child, of a covered employee who has family coverage is automatically enrolled in this Plan. The enrollee must notify the Insurance Department of any newly acquired dependent.

TIMELY ENROLLMENT

Timely Enrollment - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than one month after the person becomes eligible for the coverage.

Coverage will become effective on the first day of the month following the month in which the employee applies for coverage.

If two employees (spouses) are covered under the Plan and the employee covering any dependent children terminates coverage, the dependent coverage may be continued by the other covered employee; no applicable waiting period is required if coverage has been continuous.

LATE ENROLLMENT

Employees who did not enroll in this Plan when first eligible may choose to enroll at a later date. Coverage will become effective no earlier than the first day of the third month following the month of enrollment application.

ENROLLMENT AFTER INITIAL ELIGIBILITY

Individuals Losing Other Coverage. An employee or dependent that is eligible, but not enrolled in this Plan, may enroll if each of the following conditions are met:

- The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

- If required by the Plan Administrator, the employee stated in writing at the time that coverage was offered, that the other health coverage was the reason for declining enrollment.

- The coverage of the employee or dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment or Jefferson County contributions towards the coverage were terminated.

- The employee or dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or Jefferson County contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

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

- The employee or dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.

- The employee or dependent has a loss of eligibility due to the Plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

- The employee or dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status such as attaining the maximum age to be eligible as a dependent child under the Plan, death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

- The employee or dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area whether or not within the choice of the individual.

- The employee or dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, whether or not within the choice of the individual, and no other benefit package is available to the individual.

- If the employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions, or for cause such as making a fraudulent claim, that individual does not have a special enrollment right.

Dependent Beneficiaries

If the employee is a participant under this Plan or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period, and a person becomes a dependent of the employee through marriage, birth, adoption or placement for adoption, then the dependent and if not otherwise enrolled, the employee may be enrolled under this Plan as a covered dependent of the covered employee. In the case of the birth or adoption of a child, the spouse of the covered employee may be enrolled as a dependent of the covered employee if the spouse is otherwise eligible for coverage.

The dependent special enrollment period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the dependent enrolled in the special enrollment period will be effective:

- In the case of marriage, as of the date of marriage;
- In the case of a dependent's birth, as of the date of birth; or
- In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Medicaid and State Child Health Insurance Programs. An employee or dependent who is eligible for, but not enrolled in this Plan, may also enroll in this Plan when:

The employee or dependent loses eligibility under Medicaid or the state's Children's Health Insurance Program (CHIP), and the employee requests coverage under this Plan within a special enrollment period of 60 days after the date of termination of coverage; or

The employee or dependent becomes eligible for premium assistance under Medicaid or the State's Children's Health Insurance Program (CHIP) to subsidize the cost of coverage in this Plan, and the employee requests coverage under this Plan within a special enrollment period of 60 days after eligibility for a premium assistance subsidy is determined.

EFFECTIVE DATE

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

- The eligibility requirement.
- The active/retired employee requirement.
- The enrollment requirements of the Plan.

Effective Date of Dependent Coverage. A dependent's coverage will take effect on the day that the eligibility requirements are met; the employee is covered under the Plan; and all enrollment requirements are met.

Waiting Period. A waiting period for initial employee and dependent coverage may apply under the terms of any applicable collective bargaining agreement; such waiting period for coverage will not exceed 90 days.

A waiting period, not exceeding 90 days will also apply if an employee re-enrolls for coverage after voluntarily cancelling coverage or when coverage terminated for failure to pay premiums.

Coverage will become effective on the first day of the month following the month during which the waiting period was satisfied.

TERMINATION OF COVERAGE

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

Jefferson County or the Plan has the right to rescind any coverage of the employee, retiree and/or dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan. Jefferson County or the Plan may either void coverage for the employee, covered retirees and/or covered dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days of advance written notice of such action. Jefferson County will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. Jefferson County reserves the right to collect additional monies if claims are paid in excess of the employees, retirees and/or dependent paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

- The date the Plan is terminated.
- The day the covered employee ceases to be in one of the eligible classes. This includes death or termination of active employment of the covered employee or an active employee who does not meet the qualifications for continued coverage as a retiree. (See the Continuation Coverage Rights under COBRA.)
- The last day of the period for which the required contribution has been paid if the charge for the next period is not paid when due. Contact the County Insurance Department for details concerning cancellation due to failure to pay contributions.
- The last day of the month in which the employee requests to voluntarily cancel coverage. Contact the County Insurance Department for details concerning voluntary cancellation.

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

When coverage terminates due to voluntary cancellation or for failure to pay required contributions, re-enrollment and continuation of coverage as a retiree may be affected; contact the County Insurance Department for details.

Except in certain circumstances such as voluntary cancellation of coverage and failure to pay required premiums, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA.

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

- **For disability leave only:** the date Jefferson County ends the continuance.

- **For leave of absence without pay and seasonal layoff only:** the date Jefferson County ends the continuance. Both Jefferson County's and the employee's share of contribution must be paid by the employee in order to continue coverage.

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

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

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

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the employee and his or her covered dependents if the employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Reinstating a Terminated Employee. A terminated employee who is reinstated will be required to satisfy the Eligibility and Enrollment requirements described below:

- If the employee was enrolled in the Plan during his or her first period of employment and is reinstated before that coverage expires, coverage will be continuous.

- If the employee was enrolled in the Plan during his or her first period of employment and is reinstated after that coverage expires, the employee who is reinstated will be treated as a new hire and be required to satisfy all applicable eligibility and enrollment requirements. Coverage is not retroactive.

- If the employee was eligible but not enrolled in the Plan during his or her first period of employment and is reinstated within two months after termination, coverage will become effective no sooner than the first day of the third month following the month in which the employee applies for coverage.

- If the employee was eligible but not enrolled in the Plan during his or her first period of employment and is reinstated more than two months after termination, the employee who is reinstated will be treated as a new hire with coverage as described under effective date.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to employees and their dependents covered under the Plan before leaving for military service. The maximum period of coverage of a person under such an election shall be the lesser of:

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

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

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

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

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

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

- The date the Plan or dependent coverage under the Plan is terminated.

- The date that the employee's coverage under the Plan terminates for any reason including death. (See Survivor Dependents; Continuation Coverage Rights under COBRA.)

- The date a covered spouse loses coverage due to loss of dependency status.
(See the Continuation Coverage Rights under COBRA.)

- On the first date that a dependent child ceases to be a dependent as defined by the Plan.
(See the Continuation Coverage Rights under COBRA.)

- The last day of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

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

Survivor Dependents. Dependents enrolled in family coverage at the time of an active or retired employee's death can elect to maintain Plan enrollment eligibility under certain circumstances. Coverage under this provision terminates when a surviving spouse remarries or a surviving child no longer qualifies as a dependent under the Plan.

Extended Coverage. No contributions will be required from the survivor dependent(s) for three months of extended coverage following the month in which the employee's death occurred. The survivor(s) must enroll within 90 days of the date of death.

If the deceased employee contributed to the cost of coverage, one month's contribution will be applied to the survivor coverage for the month following the month in which the employee's death occurred.

The second and third months of coverage that follow the month of the employee's death are provided at no cost to the survivor(s).

Survivor coverage terminates on the last day of the third month following the month in which the death occurred.

Certain surviving dependents may also be eligible to continue Plan coverage after the period of extended survivor coverage ends if:

The deceased employee or retiree had completed 10 years of active service (with the County, the State of New York, and/or any political subdivision of New York State eligible to participate in the State Health Insurance Program) or was a teacher who was eligible for vesting in the Teachers' Retirement System prior to death. The entire cost of coverage is paid by the survivor dependent(s).

If the death of an active employee was the result of a work-related Injury, irrespective if length of active service. The surviving dependent(s) may be eligible to continue coverage if they are entitled to and apply for accidental death benefits. Contact the County Insurance Department for details on the application and the cost, if any, for continued coverage.

If a surviving dependent does not qualify under any of the above, see Continuation Coverage Rights under COBRA.

If the dependent survivor is also eligible (or becomes eligible) under the Plan as an active or retired employee of the County or the State of New York, he or she may elect to continue coverage as an active or retired employee after the end of the extended coverage period. If such active or retired employee coverage ends, dependent survivor coverage may be re-established if Plan coverage has been continuous.

The County Insurance Department can provide full details concerning survivor dependent eligibility.

EXTENSION OF HOSPITAL AND MEDICAL/SURGICAL/MAJOR MEDICAL BENEFITS

If coverage ends while a covered employee is totally disabled, this Plan will extend Hospital Benefits while he or she is totally disabled for expenses incurred within three (3) months from the date that the covered employee's coverage ended or during a Hospital stay which began within that three-month period.

If coverage ends while a covered employee is totally disabled, this Plan will extend Medical/Surgical and Major Medical Benefits for the covered employee's disabling condition only. No contributions will be required.

This extension will not be offered if Plan coverage ended due to non-payment of contributions.

The extension will terminate at the earliest of:

- The date that the total disability ends;
- Eighteen (18) months from the date that the covered employee's coverage ended. This extension will run concurrently with any continuation of coverage provisions under this Plan. The covered employee must provide proof of total disability if the Plan requests it.

MEDICAL BENEFITS

Verification of Eligibility. Call the toll-free number found on your ID card to verify eligibility for Plan benefits **before** the charge is incurred.

All benefits described in this Plan are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is medically necessary; that charges are usual and reasonable; that services, supplies and care are not experimental and/or investigational.

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

Note: The following services must be pre-certified or reimbursement from the Plan may be reduced.

Precertification of the medical necessity for the following non-emergency services before inpatient medical and/or surgical services are provided:

- Inpatient Hospitalizations (except emergency, urgent, and maternity stays)
- Rehabilitation facility inpatient stays
- Skilled nursing facility inpatient stays
- Substance use disorder/mental disorder inpatient admissions

Note: Notice of an emergency, urgent, or a maternity stay is requested to review medical necessity.

Outpatient Diagnostic Testing Review. Benefits may be reduced if diagnostic testing is rendered in an inpatient setting.

Ambulatory Surgery Review: Benefits for the following procedures may be reduced if rendered in an inpatient setting:

- Breast biopsy
- Bronchoscopy
- Colonoscopy
- Dilation and curettage (D&C) – diagnostic
- Excision of skin lesion
- Gastroscopy
- Laparoscopy - diagnostic
- Myringotomy
- Vasectomy

Please see the Cost Management Services section in this booklet for details.

Network Providers. The Plan is a plan which contains multiple network provider organizations. You can find in-network providers by visiting the Third Party Administrator’s website.

This Plan’s Third Party Administrator has entered into an agreement with certain hospitals, physicians and other health care providers, which are called network providers. The Plan agrees to reimburse the provider directly for covered services.

When a covered person uses a network provider, that covered person will receive a higher payment from the Plan than when an out-of-network provider is used. It is the covered person's choice as to which

provider to use.

If a covered person is not able to locate an in-network provider for preventive care services, there will be no cost sharing for the out-of-network provider's charges for those covered preventive care services.

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

Coordination of Benefits. When services and supplies are rendered and billed by a network or out-of-network provider and this Plan is the secondary payer of benefits according to the Coordination of Benefits provision and Medicare Secondary Payer rules, all benefits will still apply. Copayments still apply.

See the sections entitled Coordination of Benefits and Medicare.

Deductibles/Copayments Payable by Plan Participants. Deductibles/copayments are dollar amounts that the covered person must pay before the Plan pays.

A deductible is an amount of money that is paid once a calendar year per covered person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered charges. Each January 1st, a new deductible amount is required. However, covered charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next calendar year as well as the current calendar year. Deductibles accrue toward the 100% maximum out-of-pocket payment.

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

Government Mandates. The Plan Administrator, subject to the terms and conditions of the Plan as directed and approved by the County, agrees to adopt or otherwise incorporate federal mandates for health coverage whenever such legislation is directed at this type of health plan coverage.

COST MANAGEMENT SERVICES

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

Cost Management Services

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

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

The patient or family member must call this number to receive certification of certain Cost Management services. This call must be made in advance of services being rendered.

Any reduced reimbursement due to failure to follow these cost management procedures will not accrue

toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

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

The program consists of:

- Inpatient hospitalizations (except emergency, urgent, and maternity stays)
- Rehabilitation facility inpatient admissions
- Skilled nursing facility inpatient admissions
- Substance Use Disorder/Mental Disorder inpatient admissions

Note: Notice of an emergency, urgent, or a maternity stay is requested to review medical necessity.

Outpatient Diagnostic Testing Review. Benefits may be reduced if diagnostic testing is rendered in an inpatient setting.

Ambulatory Surgery Review: Benefits for the following procedures may be reduced if rendered in an inpatient setting:

- Breast biopsy
- Bronchoscopy
- Colonoscopy
- Dilation and curettage (D&C) – diagnostic
- Excision of skin lesion
- Gastroscopy
- Laparoscopy - diagnostic
- Myringotomy
- Vasectomy

Retrospective Review: of the medical necessity of the listed services provided on an emergency basis;

Concurrent Review: based on the admitting diagnosis, of the listed services requested by the attending physician; and certification of services and planning for discharge from a medical care facility or cessation of medical treatment.

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

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

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

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

Pre-certification. Before a covered person enters a medical care facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a medical care facility is one that can be scheduled in advance.
The utilization review program is set in motion by a telephone call from the covered person. Contact the utilization review administrator at the telephone number on your ID card before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered employee
- The name, member ID number and address of the covered employee
- The name of the employer
- The name and telephone number of the attending physician
- The name of the medical care facility, proposed date of admission and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

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

If the covered person does not receive authorization as explained in this section, the benefit payment for inpatient charges will be reduced by $250 (inpatient deductible).

Notice for emergency, urgent, or maternity admissions. Precertification is not required for emergency, urgent, or a maternity admissions. If there is an **emergency, urgent, or maternity** admission to the medical care facility, the patient, patient's family member, medical care facility or attending physician should notify the utilization review administrator **within 24 hours or within one business day** after the admission to review medical necessity and begin concurrent review.

Concurrent Review, Discharge Planning. Concurrent review of a course of treatment and discharge planning from a medical care facility are parts of the utilization review program. The utilization review administrator will monitor the covered person's medical care facility stay or use of other medical services and coordinate with the attending physician, medical care facilities and covered person either the scheduled release or an extension of the medical care facility stay or extension or cessation of the use of other medical services.

If the attending physician feels that it is medically necessary for a covered person to receive additional services or to stay in the medical care facility for a greater length of time than has been pre-certified, the attending physician must request the additional services or days.

OUTPATIENT DIAGNOSTIC TESTING REVIEW

Before a covered person is admitted as an inpatient for the purpose of diagnostic testing, he or she must contact the utilization review administrator to determine if diagnostic tests performed in an inpatient setting are medically necessary.

Please call the Third Party Administrator at the number listed on the ID card.

Failure to follow this procedure could reduce reimbursement received from the Plan.

If the covered person does not contact the administrator and receives the test as an inpatient as explained in this section, the inpatient charges billed will be reduced by $250. If employee follows this procedure and still has the test performed on an inpatient basis, no benefit reduction will be applied.

AMBULATORY SURGERY REVIEW

Certain elective procedures are performed either inappropriately or unnecessarily in an inpatient setting.

An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

Before a covered person is admitted as an inpatient to have a surgery performed that is on the list, the covered person must contact the utilization review administrator.

Failure to follow this procedure review could reduce reimbursement received from the Plan.

If the covered person does not receive authorization and receives the surgery as an inpatient as explained in this section, benefit payment for the inpatient charges billed will be reduced by $250 and benefit payment for the charges billed by the surgeon will be reduced by 50% up to a maximum of $250. This benefit reduction will not apply if an outpatient facility is not available or if an inpatient confinement is medically necessary.

CASE MANAGEMENT

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

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

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring hospital or skilled nursing facility;
- determining alternative care options; and
- assistance in obtaining any necessary equipment and services.

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

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

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

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

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

COMPREHENSIVE MEDICAL BENEFITS

Comprehensive Medical Benefits apply when covered charges are incurred by a covered person for care of an injury or sickness and while the person is covered for these benefits under the Plan.

Deductible Amount. This is an amount of covered charges for which no benefits will be paid. Generally, before benefits can be paid in a calendar year a covered person must meet the deductible shown in the Schedule of Benefits.

This amount will accrue toward the 100% maximum out-of-pocket payment.

Deductible Three Month Carryover. Covered charges incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next calendar year.

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

Deductible for a Common Accident. This provision applies when two or more covered persons in a family unit are injured in the same accident.

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

Benefit Payment

Each calendar year, benefits will be paid for the covered charges of a covered person that are in excess of any applicable deductible, any copayments and any amounts paid under hospital benefits for the same services. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the maximum benefit amount or any listed limit of the Plan.

Spell of Illness

The Plan pays up to 365 days per spell of illness, as defined, for certain inpatient and home care services as shown in the Schedule of Benefits. The spell of illness limit applies to inpatient hospital care, including maternity admissions, mental health disorders, substance use disorders, skilled nursing facility care, rehabilitation facility care; and home health care.

Out-of-pocket Limit

Covered charges are payable at the percentages shown each calendar year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, covered charges incurred by a covered person will be payable at 100% (except for the charges excluded) for the rest of the calendar year. Copayments accrue toward the 100% maximum out-of-pocket payment.

Maximum Benefit Amount

The maximum benefit amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all covered charges incurred by a covered person.

Covered Charges

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

MEDICAL SERVICES AND SUPPLIES

Words Used in this Section. The word “you”, “your” or “yours” refers to you, the employee to whom this booklet is issued and to any plan members of your family who are also covered under this Plan.

INPATIENT HOSPITAL CARE

This Plan will pay for your care when you are in inpatient in a hospital or birthing center as described below. This plan will pay up to 365 benefit days of care for each spell of illness.

Hospital Services Covered. This Plan will usually pay for all the diagnostic and therapeutic services provided by the hospital, however, the service must be given by an employee of the hospital, the hospital must bill for the service and the hospital must retain the money collected for the service. Those services include, but are not limited to:

- Use of the operating, recovery, intensive care and cystoscopy rooms and equipment
- Laboratory and pathology examinations
- Basal metabolism tests
- Use of cardiac equipment
- Oxygen and use of equipment for administration
- Prescribed drugs and medicines
- Intravenous preparations, vaccines, sera and biologicals
- Blood and/or blood products, upon satisfactory evidence that local conditions make it necessary to incur expenses for blood or blood products
- Use of transfusion equipment
- Dressings and rigid material casts
- X-ray examinations, radiation therapy and radioactive isotopes
- Chemotherapy
- Anesthesia supplies, equipment and administration by a hospital staff employee
- Physiotherapy and hydrotherapy
- Ambulance service when supplied by and billed by the admitting hospital
- Semi-private room: A semi-private room is one which the hospital considers to be semi-private. This Plan will only pay the hospital’s most common semi-private room charge. If you occupy a private room, you will have to pay the difference between that charge and the charge for the semi-private room.

Mental or Nervous Conditions. The Plan will pay for inpatient care for mental and nervous conditions if your physician certifies that inpatient care is:

- required for your protection or for the protection of others; or
- where the course of treatment can only be carried out on an inpatient basis

The Plan will pay for care of mental or nervous conditions which is provided in an acute care general hospital or in a public hospital. A public hospital is a hospital which is operated by a governmental body.

Tuberculosis. The Plan will pay for care of tuberculosis which is provided in an acute care general or public hospital.

Birthing Center. The Plan will pay for the hospital services in for your maternity care in a birthing center which is licensed by the state in which it operates.

See Number of Days of Care Section of this Plan document.

OUTPATIENT HOSPITAL CARE

The Plan will pay for the same services provided to you in the outpatient department of a hospital as pays when you are an inpatient in a hospital. As in the case of inpatient care, the service must be given by an employee of the hospital, the hospital must bill for the service and the hospital must retain the money collected for the service.

Emergency Care for an Accident. This plan will pay for emergency care, less an $80 co-payment, if services are rendered within 72 hours of the accident. There will be no co-payment if you or your eligible dependents are admitted to the hospital on an inpatient basis.

Emergency Medical Condition Care for Sudden Onset of an Illness. This Plan will pay for the sudden onset of an illness, less an $80 copayment, if care is given within 24 hours after the first appearance of the symptoms of the illness. There will be no copayment if you or your eligible dependents are admitted to the hospital on an inpatient basis. Payment will only be made when all of the following conditions are met:

- There is a sudden, unexpected onset of a medical condition;
- Immediate care is necessary to prevent what could reasonably be expected to result in either placing your life in jeopardy or serious impairment to your bodily functions.

Surgery. This Plan will pay for outpatient surgery, subject to a copayment of $20. The Plan will not pay for follow up care for surgery, such as removal of sutures and checkup visits.

Radiation Therapy. This Plan will pay for radiation therapy, subject to a copayment of $20.

Diagnostic X-rays and Laboratory Tests. Diagnostic x-rays and laboratory tests will be paid for subject to a copayment of $20 per service, only if they are necessary for the treatment or diagnosis of your illness or injury and they are ordered by your doctor. You must be present at the outpatient department. Payment will not be made for doctors' charges for interpretation of x-rays or laboratory tests.

Pre-admission Testing. The Plan will pay for pre-admission testing subject to a co-payment of $20. The following must be met:

- The treatments are ordered by a physician as a preliminary step in your admission to a hospital as a

registered bed patient for surgery;

- They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;
- You have a reservation for the hospital bed and for the operating room before the tests are given;
- You are physically present at the hospital when the tests are given;
- Surgery actually takes place within 14 days after the tests are given.

Physical Therapy. This Plan will pay for physical therapy, subject to a copayment of $20 per visit, only when all of the following conditions are met:

- The treatments are ordered by your doctor; and
- The treatments are in connection with the same illness for which you had previously been hospitalized or related to inpatient or outpatient surgery;
- The treatments must start within six months from your discharge from the hospital or within six months from the date surgery was performed.

No payment will be made for physical therapy given after 365 days from the date you were discharged from the hospital or the date of the surgery.

Hemodialysis Treatment. The treatments must be ordered by your doctor.

Chemotherapy. The treatments must be ordered by your doctor. However, payment will not be made for:

- Oral chemotherapy; or
- Subcutaneous injection; or
- Intramuscular injection.

SKILLED NURSING FACILITY

Conditions for Skilled Nursing Facility Care. This Plan will pay for your care in a skilled nursing facility described in when you meet the following conditions:

Care in a skilled nursing facility must be medically necessary. Care is medically necessary when it must be furnished by skilled personnel to assure your safety and achieve the medically desired result. Custodial care, which is care which is primarily assistance with the activities of daily living, is not covered. In order to determine whether care is medically necessary, the guidelines by the Federal Government's Medicare program will be applied.

Coverage will only be provided for as long as inpatient hospital care would have been required if care in a skilled nursing facility were not provided.

Benefits in a skilled nursing facility are not provided by this Plan if you are eligible to receive primary benefits from Medicare. You are not eligible to receive this Plan's benefits if your Medicare benefits for skilled nursing facilities have been exhausted.

The facility must be either:

- Accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Hospitals; or
- Certified as an In-Network Skilled Nursing Facility under Medicare.

A list of facilities within New York State which qualify is available from this Plan's Administrator.

Covered Services. This Plan will pay the charges of a skilled nursing facility for:

- A semi-private room. If you occupy a private room, this Plan will pay an amount equal to the facility's most common charge for a semi-private room. You must pay the excess portion of the charge.
- Physical, occupational and speech therapy
- Medical social services
- The drugs, biologicals, supplies appliances and equipment furnished for use in the facility and which are ordinarily provided by the facility to patients.
- Other services necessary for your health which are generally provided by the facility

See Number of Days of Care Section of this Plan Document

HOME HEALTH CARE

Type of Home Health Care Agency. This Plan will pay for home care visits provided by a home care agency certified under Article 36 of the New York State Public Health Law. This Plan will not pay for home care by an agency which is only licensed under Article 36. If the home care is provided outside of New York State, the provider of the care must have an appropriate operating certificate issued by the appropriate state agency in the state where the care is rendered. The provider outside of New York State must be a hospital or nonprofit or public health service or agency.

Conditions for Home Health Care. This Plan will pay home care visits only if the following conditions are met:

If you did not receive home health care visits, you would have to be hospitalized in a hospital or cared for in a skilled nursing facility. In other words, the home health care visits are a substitution for hospital care or care in a skilled nursing facility.

A plan for your home health care is established in writing and approved by a physician.

Home Health Care Services Covered. Payment will be made for the following home health care services:

- Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.).
- Part-time or intermittent home health aide services which consist primarily of caring for the patient.
- Physical, occupational or speech therapy if the home care agency or hospital provides these services.
- Medical supplies, drugs and medications prescribed by a doctor, but only if this Plan would have paid for those items if you were in a hospital or confined in a skilled nursing facility.
- Laboratory services provided by or on behalf of the home care agency or hospital.

Number of Home Care Visits. Each visit by a member of a home care team is counted as one home care visit. Four hours of some health aide service are counted as one home care visit.

See Number of Days of Care Section of this Plan Document

HOSPICE CARE

Hospice Organization. This Plan will pay for hospice care provided by a Hospice organization which has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the hospice organization must have an operating certificate issued under criteria similar to those used in New York by a state agency in the state where the hospice care is provided.

Hospice Agreements. The hospice organization must have an operating agreement with this Plan's Administrator. The operating agreement must state the method which will be used to pay for the hospice care.

Hospice Care Covered. Hospice care is covered during the period when the hospice has accepted you for its hospice program. The following services are covered:

- Bed patient care either in a designated hospice unit or in a regular hospital bed.
- Day care services provided by the hospice organization.
- Home care and outpatient services which are provided by the hospice and for which the hospice charges you.

The services may include at least the following:

- Intermittent nursing care by an R.N., L.P.N. or Home Health Aides
- Physical therapy
- Speech therapy
- Occupational therapy
- Respiratory therapy
- Social services
- Nutritional services
- Laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms
- Medical supplies
- Drugs and medicines prescribed by a physician and which are considered approved under U.S. Pharmacopoeia and/or National Formulary. This Plan will not pay when the drug or medication is of an experimental nature.
- Medical care provided by the hospice physician
- Respite care
- Bereavement services provided to your family during your illness and until one year after death.

NUMBER OF DAYS OF CARE

This Plan will pay up to 365 benefit days of care for each spell of illness. The days of care may be for inpatient hospital care, maternity care in a birthing center, skilled nursing facility care or home health care. A spell of illness begins when:

- You are admitted to a hospital or birthing center; or
- You are admitted to a skilled nursing facility; or
- You receive home health care

The spell of illness ends when, for a period of at least 90 days, you have not:

- Been a patient in a hospital or birthing center; or
- Been a patient in a skilled nursing facility; or
- Received home health care per place of service:

Inpatient Hospital Care. Each day of inpatient hospital care or care in a birthing center counts as one day of care toward the 365-benefit-day limit

Skilled Nursing Facility Care. Each day of care in a skilled nursing counts as one-half benefit day of care. For example, 20 days in a skilled nursing facility counts as 10 benefit days of care toward the 365-benefit-day limit.

Home Health Care. Each home care visit counts as one-third benefit day. For example, 30 home care visits count as 10 benefit days of care toward the 365-benefit-day limit.

Outpatient Hospital Care and Hospice Care. Outpatient hospital care is provided whenever you meet the requirement. The 365-benefit-day limitation does not apply to outpatient care. Hospice care is provided for the length of time that the hospice has accepted you for its program. The 365-benefit-day limitation does not apply to hospice care.

AMBULANCE SERVICE

This Plan will pay up to $50 for each trip in an ambulance to and/or from a hospital. The service must be provided by a professional ambulance service which bills for its services and use of an ambulance must be medically necessary. (See the Medical/Surgical section for possible additional coverage).

SUBSTANCE ABUSE TREATMENT

This Plan will pay for outpatient visits in an approved facility for the diagnosis and treatment of substance abuse subject to a copayment of $20 visit. An approved facility is defined as the following and can include a government Hospital:

Within New York State. Any facility which is certified by the State of New York Division of Alcoholism and Alcohol Abuse as an alcohol treatment program.

Outside of New York State. Any facility which is approved by the Joint Commission on Accreditation of Hospitals as an alcohol treatment program.

MEDICAL/SURGICAL AND MAJOR MEDICAL EXPENSE BENEFITS

The Jefferson County Health Benefits Plan is your hospitalization coverage together with your in-network participating provider program for Medical/Surgical and Major Medical Expense Benefits. The following describes both portions of your Medical/Surgical and Major Medical coverage.

The following **covered charges** are included in the in-network provider program and the charges for these services will be paid directly to the in-network provider you have chosen. You do not pay these charges yourself, the program has been designed to make payment for you.

Office and Home Visits: You are covered for doctor's office visits and home visits by a doctor for general medical care, diagnostic visits, treatment of Illness, allergy desensitization, immunization visits, subject to a copayment of $20 for both in-network and out-of-network providers, per visit. General medical care includes routine pediatrics and physical exams.

Note: This benefit for office and home visits is payable, per schedule of allowance for both in-network and out-of-network providers and not subject to the deductible and coinsurance. Any excess payment made by the subscriber over the schedule of allowance may not be submitted to major medical.

In Hospital Doctor's Visits: You are covered for doctor's visits while an inpatient in a hospital if such visits are not related to surgery. Benefits for visits related to surgery are included in the scheduled amount for the surgery.

Surgery: You are covered for the services of a doctor for surgery, including post-operative care, whether performed in or out of a hospital. Benefits for certain surgical procedures may be reduced under the Ambulatory Surgery Program.

In Hospital Anesthesia: You are covered for anesthesia services if such services are performed in connection with inpatient surgery, maternity care or shock therapy. You are covered if the anesthesia services are administered by your doctor, your doctor's assistant or by a hospital employee.

Maternity Care: You are covered for care related to pregnancy and childbirth. This includes care given before and after childbirth and for complications of pregnancy. Payments of maternity benefits may be made in two payments (at reasonable intervals) for covered care and treatment rendered during pregnancy and a separate payment for the delivery and post-natal care provided.

Maternity care may be rendered by a doctor or licensed certified nurse midwife. The nurse midwife must be:

- licensed or certified to practice nurse midwifery; and
- permitted to perform the service under the laws of the state where the services are rendered.

Specialist Consultations: Your doctor may refer you to a specialist for a consultation. During the consultation, the specialist will evaluate your medical condition and give you and your doctor advice on how to proceed with your care. This specialist may or may not be an in-network provider. If you wish to use a specialist who is an in-network provider, you should refer to the list of in-network providers in your area. When you use an out-of-network provider, benefits are payable under the Major Medical portion of this Plan.

You are covered for one out of hospital consultation in each specialty filed per calendar year for each condition being treated. You are covered for one inpatient consultation in each specialty field, per confinement, for each condition being treated.

You are **NOT** covered for consultations in the fields of pathology, roentgenology or anesthesiology.

Diagnostic Laboratory and X-ray Examinations: You are covered for diagnostic laboratory and x-ray procedures performed out of a hospital, subject to a copayment of $20 per service. You are also covered for the separate interpretation of x-rays by a radiologist if the radiologist bills separately. Diagnostic laboratory and x-ray examinations are covered when performed in the doctor's office.

Chiropractors: You are covered for visits to your chiropractor and also for necessary related x-rays, subject to a copayment of $20 per visit. The extent of coverage will be determined by the Third Party Administrator based on an ongoing review on case by case basis.

Visiting Nurse Service: You are covered for part-time or intermittent visits by participating nurses or by registered nurses from accredited participating nurse services. Care must be under the supervision of a doctor.

Podiatry: You are covered for the service of a podiatrist except for routine care of the feet. These services are subject to a copayment of $20 per visit.

Physiotherapy: You are covered for the application of physio-treatment and/or treatment by osteopathic manipulation, subject to a copayment of $20 per visit. This benefit is not available if it is covered by the hospital portion of this Plan.

Radiation Therapy: You are covered for radiation therapy given in or out of a hospital.

Shock Therapy: You are covered for shock therapy treatments given in or out of a hospital.

Spell of Illness: A spell of illness begins when you are admitted as a patient to a hospital, birthing center or skilled nursing facility or receive home health care. When you are no longer a patient or receiving home health care for a period of at least 90 days for the same illness, the spell of illness ends and the benefits listed above are available to you again starting with the date of your new spell of illness.

MAJOR MEDICAL EXPENSE PROGRAM

If you incur covered charges and do not use an in-network provider, your benefits will be determined under the Major Medical portion of this Plan. This segment describes your coverage under the Major Medical expense program and how the program works.

Assignment of benefits to an out-of-network provider is not permitted. Assignments will be made to hospitals and approved facilities. You are responsible for the charges billed and must submit a claim for benefits due. These benefits are calculated based on the following:

First, you are liable for the deductible, it is your responsibility.

After the deductible, covered charges are considered for payment. In most instances, you will receive benefits based on 80% of these expenses. You pay the balance of 20%. This is called coinsurance.

Annual Deductible. The annual deductible amount is $400 for each covered person, in each calendar year except that:

The annual deductible amount in each calendar year shall not exceed $1000 for all members of your family combined; only one deductible amount of $400 will apply to all covered charges incurred by your family as a result of any one accident during the calendar year in which the accident occurs; and any covered medical expense incurred by you and applied to your deductible during the last three months of a calendar year shall be applied to your annual deductible amount for the next calendar year.

Coverage. This Plan will pay Major Medical expense benefits to the extent covered charges in a calendar year exceed the deductible and coinsurance.

Covered Major Medical Expenses. Covered charges are defined as the usual and reasonable charge for covered medical services performed or supplies prescribed by a doctor, except as otherwise provided, due to your sickness, injury or pregnancy. These services and supplies must be medically necessary in terms of generally accepted medical standards as determined by the Third Party Administrator. No more than the reasonable and customary charge for medical services and supplies will be covered by this Plan.

Under the Major Medical Expense Program, covered charges include charges for the following services or supplies:

HOSPITALS AND APPROVED FACILITIES

Services of hospitals for which this Plan's hospital benefits are provided are covered excluding:

- Charges for room and board and special services provided to you as an inpatient during a period for which the hospital benefits are provided;
- Any room and board charges in excess of the hospital's most common semi-private room rate, if a private room is used;
- Charges for outpatient services covered by the hospital benefits portion of this plan; and
- Services not billed by the hospital.

Services of a private proprietary hospital for the treatment of mental and nervous conditions are covered.

Services of a private proprietary hospital for inpatient psychiatric and alcoholism care are covered at 80% of the hospital's semi-private room rate, with a maximum covered charge of $450 per day, and a lifetime maximum limit of $50,000 after the annual deductible is met.

Inpatient services by approved facilities, other than a hospital, for treatment of alcoholism and/or substance abuse are covered for a maximum total confinement of seven weeks in any calendar year.

Outpatient services in approved facilities, other than a hospital, for treatment of substance abuse are covered up to a maximum of thirty treatments in a calendar year.

REMEMBER: You must comply with the Benefits Management Program requirements for a hospital or approved facility admission. Refer to the details of how this program works in the Hospital section of this booklet.

If and when it is determined that inpatient care is no longer medically necessary, benefits will cease and notice will be given to the hospital or approved facility and patient the day before your benefits end.

Doctors. Services of doctors are covered except that:

Services received on an inpatient basis for the treatment of mental and nervous conditions will be payable only during a period in which benefits are payable under this Plan for room and board. Services rendered by a physician for inpatient psychiatric care in a hospital will be paid at 80% of the usual and reasonable charges with a maximum of $75 per day, after the annual deductible is met.

Outpatient services for the treatment of mental and nervous conditions will be payable as set forth in the outpatient psychiatric services segment.

Nursing Services. Services of a nurse are covered, not to exceed an annual limit of $25,000, provided such services:

- Are prescribed by a doctor; and
- Are rendered by a Registered Professional Nurse (R.P.N.); or
- Are rendered by a licensed practical nurse and your doctor certifies that an R.N. is not available;
- Are not rendered by someone who lives in your home or by a member of your immediate family.

The services rendered must be medically necessary and must require the skills of nursing care when that care is needed to manage medical problems of acutely ill patients. This does not include assistance with daily living, companionship or any other service which can be given by a less skilled person, such as a home health aide. The first 48 hours of such services in a calendar year are NOT a covered expense.

Nurse Midwife Services. Maternity services of a nurse midwife are covered if the nurse midwife is:

- Licensed or certified to practice midwifery; and
- Permitted to perform the service under the laws of the state where the services are rendered.

Chiropractors. Services of a duly licensed chiropractor will be covered for:

- Manual manipulation of the spine to correct a subluxation that can be shown by x-ray; and
- Other services prescribed by a doctor.

Podiatrists. Services of a duly licensed podiatrist for the treatment of diseases, injuries and malformation of the foot are covered, EXCEPT that those treatments or supplies listed in the exclusions segment are NOT covered charges.

Preventive Care Services. Covered charges under Major Medical Benefits are payable for routine preventive care as described in the Schedule of Benefits. The Plan will comply with all mandated coverage provisions of the Patient Protection and Affordable Care Act. The following is a list of the most common services. This list is subject to change based on evidence-based items or services with an “A” or “B” rating from the United States Preventive Services Task Force; evidence-informed preventive care and screenings for infants, children, adolescents and women provided in guidelines supported by the Heath Resources and Services Administration; and immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices (ACIP). The Plan will comply within the first plan year after one year of the effective date of all new recommendations or guideline changes. The Plan will not cover any item or service that is no longer a recommended preventive service. Ancillary charges associated with any preventive care service will be available at no cost share.

Preventive care services/routine well care is care by a physician that is not for an injury or sickness.

Bone Density Testing. Bone mineral density measurement or test to detect osteoporosis for covered women aged 65 years or older and in younger women who are at significant risk for osteoporotic fracture.

Colorectal Cancer Screening for covered persons from age 50 -75 to include fecal occult blood testing, sigmoidoscopy, or colonoscopy.

Mammogram Based on individual risks prior to age 40 and every two years from age 40 to 74.

Nutritional Counseling. The Plan will cover wellness (no underlying chronic condition required) nutritional counseling up to the benefit maximums shown in the Schedule of Benefits. Services must be rendered by certified nutritionist or certified and registered dietician.

Prostate-Specific Antigen (PSA) and/or Digital Rectal Examination. Benefits are available for routine

screening of the prostate gland, including digital rectal examination and PSA (prostate-specific antigen) testing.

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

Routine Adult Physical Exam to include screening tests and age-appropriate immunizations.

Routine Child Care is routine care by a physician that is not for an injury or sickness, to include health care visits. See the Schedule of Benefits regarding coverage for immunizations.

Smoking Cessation Counseling. The Plan covers charges related to tobacco use or smoking cessation counseling that is rendered by or prescribed by a physician.

Breastfeeding Support, Supplies and Counseling. In conjunction with each birth, the Plan includes coverage for comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period and the rental or purchase of breastfeeding equipment. Related, disposable supplies used with the breast feeding equipment are also covered.

BRCA Genetic Counseling/Testing. Screening for BRCA1 or BRCA2 genes for women whose family history places them at increased risk for BRCA mutations. The benefit includes related screening for BRCA1 or BRCA2 genes for women whose family history places them at increased risk for BRCA mutations.

Contraceptive Management. Contraception methods (all FDA-approved contraceptive methods and sterilization procedures) and patient education and counseling for women of reproductive age. Contraceptive methods do not include abortifacient drugs. This includes intrauterine devices (IUDs) and other FDA approved barrier, injectable, and implantable methods and the related provider charges.

Coverage for other contraceptives is available under Prescription Drug Benefits shown later in this document.

Gynecological Exam and Pap Smear/Screening Cervical Cytology to include:

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

Human Papillomavirus (HPV) DNA testing for women with normal cytology results; screening begins at age 30 years and occurs no more frequently than every three years.

Prenatal Testing, as mandated as covered under the federal Patient Protection and Affordable Care Act for non-grandfathered health plans.

Screening for gestational diabetes between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

Well-Woman Visit for adults to obtain all recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. Additional visits may be necessary to obtain all USPSTF recommended preventive services, depending on the woman's health status, needs, and risk factors.

The visit should include annual screening and counseling for interpersonal and domestic violence, annual screening and counseling for human immune-deficiency virus (HIV) infection for all sexually active women and annual counseling for sexually transmitted infections for all sexually active women.

Hearing Aids. Hearing aids, including examinations for and the fitting of, are covered up to a total maximum reimbursement of $150 in any 36 month period. These benefits are not subject to deductible or coinsurance.

Routine Newborn Child Care. Doctor's services for the routine care of a newborn child are covered with no copayment. These benefits are not subject to deductible or coinsurance.

Durable Medical Equipment. The rental or purchase, when appropriate, of durable medical equipment is covered if such equipment is customarily used for therapy and suitable for home use. In the case of purchased equipment, coverage is provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement.

Prosthetics. Artificial limbs or other prosthetic devices, including the replacement when it is functionally necessary to do so, are covered.

Ambulance Service. The following charges for ground ambulance service and air ambulance service are covered charges:

- Local professional ambulance charges which are in excess of benefits paid by the hospital portion of this plan.

- Charges of an organized voluntary ambulance service up to a maximum of $50 for under 50 miles, $75 for 50 miles or over. These amounts are not subject to deductible or coinsurance.

Eye Care Following Cataract Surgery. The charges for one set of prescription eyeglasses or contact lenses and one eye examination are covered charges following cataract surgery.

Voluntary Sterilization. Charges for voluntary sterilization are covered charges.

Miscellaneous Services. The following services are covered under the Major Medical Program when not covered by the Hospital portion:

- Diagnostic lab procedures and x-rays

- X-ray or radiation treatments

- Oxygen and its administration

- Anesthetics and their administration

- Blood transfusions, including the cost of blood and blood products; however, such costs will be covered charges only to the extent that there is evidence, satisfactory to the Third Party Administrator, that such supplies could not be obtained without cost.

Second Surgical Consultations. A second surgical consultation service will be considered a covered medical expense. If your doctor recommends surgery, and you desire a second opinion, arrangements for same will be provided by this Plan. This benefit is not subject to deductible or coinsurance.

Outpatient Psychiatric Services. You are covered for mental/nervous care including individual/family counseling if provided by doctor or psychologist licensed in the state where the service is rendered or by a certified and registered social worker with at least 6 years of post-degree experience who is qualified by the New York State Board for Social Work. Services are subject to a $20 copayment per visit.

DIABETIC SUPPLIES, EQUIPMENT AND EDUCATION

The following supplies and equipment are covered for the treatment of a diabetic condition when such supplies are ordered or recommended by a physician and when they are found to be medically necessary according to the Plan provisions:

- Blood glucose monitors (standard) and blood glucose monitors for the visually impaired
- Insulin pumps or insulin infusion pumps when medically necessary and when conventional injection therapy is found to be inadequate to treat the patient's condition are covered under durable medical equipment described below;
- Syringes are covered as described below;
- Insulin, oral agents to control blood glucose, and diabetic supplies are covered separately under Prescription Drug Benefits.
- Items such as alcohol, swabs, adhesive tape and gauze are not covered.

Diabetic self-management education and education relating to diet may be covered for a covered person with a diabetic condition. These educational services will be covered when provided by:

- A physician or his/her staff during an office visit for diabetes diagnosis or treatment. When the self-management service education is provided during an office visit, the one benefit payment for the office visit will include payment for the self-management education.
- A certified diabetes nurse educator, certified nutritionist or certified and registered dietician when referred by a physician. This education must be provided in a group setting. If it is decided that group education is not available in the patient's area, the Plan may cover individual education.

A professional provider as described above may be covered for services rendered in the patient's home. However, it must be found to be medically necessary for the patient to receive services at home.

Infertility. Care, supplies and services for the diagnosis and treatment of infertility are covered.

Expenses related to the diagnosis and treatment, including surgical correction, of an underlying medical condition that caused the infertility condition are covered separately as any other Illness.

Coverage for basic services is limited to the initial evaluation and diagnostic testing to determine an infertility condition.

Coverage for advanced services includes medically necessary expenses for non-experimental hormonal therapy, artificial insemination, *in-vitro* procedures, sonograms, related tests and other treatment that meet the protocols established by the American College of Obstetricians and Gynecologists. Treatment must be pre-approved for coverage by the Plan Administrator.

The treatment must be done on an outpatient basis in a facility or clinic that is licensed or certified for the services it provides by the state in which it operates.

Expenses related to the procurement of eggs, sperm, or embryos from or donated by the patient or by his

or her spouse are covered only when procurement is part of an approved course of treatment for artificial insemination or in-vitro fertilization or similar procedure.

The following coverage limits to advanced infertility treatment apply:

Infertility Treatment. Coverage is available for up to six ovulatory cycles per course of treatment within two years with non-experimental infertility medications. To obtain Plan approval for a course of treatment, the physician must provide a statement of medical necessity to the Plan Administrator which includes details on the condition, medical history, and the previous and proposed treatment.

Benefits are limited to the following. Initial course of infertility treatment for up to six ovulatory cycles within two years. If the first course of treatment is not successful (i.e., does not result in confirmed pregnancy), benefits will be considered exhausted. Coverage will not be available for subsequent infertility treatment expenses.

If the treatment course is successful and results in confirmed pregnancy within six cycles, coverage becomes available for a second course of infertility treatment, subject to pre-approval by the Plan Administrator. Benefits will be considered exhausted after the second course of treatment. Coverage will not be available for subsequent Infertility treatment expenses.

Exhausted coverage or benefits is for a lifetime

Artificial Insemination. Coverage is limited to artificial insemination when needed due to a medical condition of the patient or due to abnormal male (spouse of the patient) factors contributing to infertility. Coverage is available for up to a maximum of six ovulatory cycles per course of treatment within two years. To obtain Plan approval for a course of artificial insemination, the physician must provide a statement of medical necessity to the Plan Administrator which includes details on the condition, medical history, previous Infertility or artificial insemination treatment, and the proposed treatment plan.

Benefits are limited to the following: An initial course of artificial insemination for up to six ovulatory cycles within two years.

If this treatment course is not successful (i.e., does not result in a confirmed pregnancy), benefits will be considered exhausted and coverage will not be available for subsequent expenses for artificial insemination.

If the initial course of treatment is successful and results in a confirmed pregnancy within six ovulatory cycles, coverage becomes available for a second course of artificial insemination, subject to pre-approval by the Plan Administrator. Benefits will be considered exhausted after the second course of treatment and coverage will not be available for subsequent artificial insemination treatment.

Exhausted coverage or benefits are for a lifetime.

In-vitro Fertilization. Coverage is available for in-vitro fertilization, gamete interfallopian (GIFT) or similar procedures. Coverage is limited to a course of treatment up to a maximum of three ovulatory cycles at which attempted retrieval has occurred. To obtain Plan approval for a course of treatment, the physician must provide the Plan Administrator with a statement of medical necessity which includes details on the condition, medical history, history of previous infertility care and/or unsuccessful attempts to start a pregnancy, and the proposed treatment plan. Benefits are limited to the following:

Initial course of in-vitro treatment up to three ovulatory retrieval cycles within 1½ years.
If the treatment course is not successful (i.e., does not result in confirmed pregnancy), benefits will be considered exhausted. Coverage will not be available for subsequent in-vitro expenses.

If the first treatment course is successful (results in confirmed pregnancy) within three retrieval cycles, coverage becomes available for a second course of in-vitro treatment subject to pre-approval by the Plan Administrator. Benefits will be considered exhausted after the second course of treatment. Coverage will not be available for subsequent infertility care.

Exhausted coverage or benefit is for a lifetime.

Exclusions:

- Procurement expenses, whatever the reason, if they are not part of an approved course of treatment;
- All expenses related to a donor other than a spouse for the procurement of eggs, sperm or embryos or similar services, whatever the reason;
- Infertility or artificial conception services and supplies related to surrogate pregnancies;
- Surrogate maternity care;
- Expenses related to the freezing and storage of eggs, sperm, or embryos, whatever the reason;
- Expenses incurred by dependent children;
- Infertility services rendered on an inpatient basis;
- Treatment for infertility caused by menopause or climacteric syndromes;
- Reversals of sterilization procedures.

Mental Health Disorder Treatment. Covered charges will include care, supplies and treatment of mental disorders.

Regardless of any limitations on benefits for mental disorder treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on mental disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Treatment of biologically-based mental illness for adults and children is covered. “Biologically-based mental illness" is defined as a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness (such as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia, and anorexia).

Treatment of serious emotional disturbances in children under age 18 years is covered when related to attention deficit disorder, disruptive behavior disorders or pervasive development disorders and where there are one or more of the following:

- Serious suicidal symptoms or other life-threatening, self-destructive behavior
- Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors)
- Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage

- Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Covered charges for care, supplies and treatment of mental health disorders will be limited as follows:

- Inpatient treatment, as noted in the Schedule of Benefits.
- Benefits are not payable for services that consist primarily of participation in programs of a social, recreational or companionship nature.
- Outpatient Treatment, as noted in the Schedule of Benefits. Physician's visits are limited to one treatment per day.

Services must be given and billed by a medical doctor (psychiatrist) or a licensed clinical psychologist (Ph.D.), or billed by a hospital or a mental health facility, physician's corporation or clinic for the services of a licensed psychiatrist, licensed clinical psychologist, or licensed clinical social worker. Family counseling is covered.

Treatment for Morbid Obesity. Benefits are available for treatment of morbid obesity. See the Schedule of Benefits for limitations.

AMBULATORY SURGICAL SERVICES

For the procedures listed below, if the procedure is performed on an outpatient basis, the scheduled amounts under the in-network provider program or the usual and reasonable charges after the deductible under the Major Medical Program, related to the procedure, are paid in full. If the procedure is performed on an inpatient basis, you are liable for the payment of the less of 50% of the scheduled amounts related to the procedure or $250 under the in-network provider program. Under the major medical program, you are liable for the lesser of 50% of the usual and reasonable charges related to the procedure or $250, in addition to the coinsurance on the difference between the usual and reasonable charges (minus deductible, if applicable) and your payment.

These provisions shall not apply if it is documented to the Third Party Administrator's satisfaction that outpatient facilities were not available or that inpatient hospitalization was medically necessary. In such cases, the scheduled amounts are paid under the in-network provider program, and under the major medical program, benefits are based on usual and reasonable charges, subject to deductible and coinsurance.

Breast Biopsy	Diagnostic Laparoscopy	Vasectomy
Bronchoscopy	Excision of Skin Lesion	Colonoscopy
Gastroscopy	Diagnostic Dilation & Curettage	Myringotomy

DEFINED TERMS

The following terms have special meanings:

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

Allowable Fee - The usual and reasonable charges as determined by the Plan Administrator for covered medical services rendered and billed by a covered out-of-network provider. If billed by a network provider, the term allowed charge means the network scheduled allowance or negotiated allowance based on the provider's network agreement with the Plan Administrator. If Medicare is primary, the allowed charge could be based on Medicare's allowance or limiting charges. The Plan will not pay charges that exceed allowed charge. The enrollee is responsible for payment of any charges that are not allowed under the Plan.

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

Approved Clinical Trial - a Phase I-IV trial conducted for the prevention, detection or treatment of cancer or other life-threatening conditions as follows:

Federally funded or approved by NIH, CDC, AHCRQ, CMS, cooperative group or center of DOD, VA or DOE, or qualified non-governmental entity identified by NIH grant guidelines;

Study or trial conducted under FDA approved investigational new drug application;

Drug trial exempt from FDA approved investigational new drug application;

Or as amended by the federal Patient Protection and Affordable Care Act.

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

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

Brand Name means a trade name medication.

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

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

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

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

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

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

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

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

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

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

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

Employee means a person who is an active, regular employee of Jefferson County, regularly scheduled to work for Jefferson County in an employee/employer relationship.

Employer is Jefferson County.

Enrollee or Covered Enrollee is an eligible employee, retiree, survivor spouse, survivor dependent, or COBRA participant under whose member ID number enrollment is made.

Enrollment Date is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

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

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

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

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

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

If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of

treatment or diagnosis.

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

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

If any of the entities used to determine the investigational status of a drug, device, supply, treatment or any other medical service reverses, modifies, or establishes its policy for such expenses, and makes such changes retroactive, the Plan will not make payment for related retroactive incurred expenses.

The Plan will not seek refund for its previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

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

Foster Child means a child under the limiting age shown in the dependent eligibility section of this Plan for whom a covered employee or retiree has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered employee's or retiree's child; the child depends on the covered employee or retiree for primary support; the child lives in the home of the covered employee or retiree; and the covered employee or retiree may legally claim the child as a federal income tax deduction.

A covered foster child is not a child temporarily living in the covered employee's or retiree's home; one placed in the covered employee's or retiree's home by a social service agency which retains control of the child; or whose biological parent(s) may exercise or share parental responsibility and control.

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

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

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

Hospice Agency is an organization whose main function is to provide hospice care services and supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a hospice agency and supervised by a physician.

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

Hospice Unit is a facility or separate hospital unit that provides treatment under a hospice care plan and

admits at least two unrelated persons who are expected to die within six months.

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

Illness means a bodily disorder, disease, physical sickness or mental disorder. Illness includes pregnancy, childbirth, miscarriage or complications of pregnancy.

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

Infertility is the result of a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. The duration of unprotected intercourse with failure to conceive should be about 12 months before an infertility evaluation is undertaken, unless medical history, age, or physical findings dictate earlier evaluation and treatment.

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

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

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

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

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

Medical Care Facility means a hospital, a facility that treats one or more specific ailments or any type of skilled nursing facility.

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

All of these criteria must be met; merely because a physician recommends or approves certain care does not mean that it is medically necessary.

The Plan Administrator reserves the right to decide, in its discretion, if a service or supply is medically necessary.

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

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

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

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

Out-of-Pocket means the patient liability portion of the percentage copayment.

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

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

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

Plan means the Jefferson County Health Benefits Program, which is a benefits plan for certain active employees and retired employees of Jefferson County and is described in this document.

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

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

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

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

Provider - Any legally licensed physician or any physical therapist, speech therapist, certified or Licensed Clinical Social Worker (for Mental Disorder care), or other health care providers giving a covered service ordered by a physician. Any licensed independent laboratory, hospital, skilled nursing facility, substance use disorder facility, hospice agency, home health care agency; or other facility/agency included for Plan coverage. Coverage includes charges billed by urgent care facilities and other health centers or clinics for covered services given by covered physicians or other healthcare providers that would otherwise be covered by the Plan. Also, see definitions for certain providers.

To be covered, a provider must meet Plan definitions and limitations, render a covered service within Plan limitations, be operating within the scope of their license, and operating according to the laws of the jurisdiction where services or supplies are given or delivered.

Qualified Individual is a covered person who is eligible to participate in an approved clinical trial according to trial protocol with respect to the treatment of cancer or other life-threatening disease or condition, and either (i) the referring provider is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the covered person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

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

Retired Employee or Retiree is a former active employee of Jefferson County who was retired while employed by Jefferson County under the formal written plan of Jefferson County, subject to any applicable collective bargaining agreement, and who elects to contribute to the Plan the contribution required, if any.

Sickness is a person's illness, disease or pregnancy (including complications).

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

- It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- Its services are provided for compensation and under the full-time supervision of a physician.
- It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care or care of mental disorders.
- It is approved and licensed by Medicare.
- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a national accreditation organization recognized by the Plan Administrator.

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

Spell of Illness means the period of time which begins when a covered person is admitted to a hospital or other covered facility, birthing center, skilled nursing facility, or rehabilitation facility or receives home health care. It ends when the covered person has not been an inpatient in or received home health care for a period of at least 90 days for the same illness.

Spouse the person recognized as the covered employee's husband or wife under the laws of the state or other jurisdiction where the covered employee lives or was married, and shall not include common law marriages. The term "spouse" shall include partners of the same sex who were legally married under the laws of the state or other jurisdiction in which they were married.

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

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

Total Disability (Totally Disabled) means:

- In the case of an active employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of injury or sickness. Jefferson County will determine total disability.

- In the case of a dependent child, the complete inability as a result of injury or sickness to perform the normal activities of a person of like age and sex in good health.

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

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

To calculate reimbursements, the Plan will use the actual charge billed if it is less than the usual and reasonable charge.

The Plan Administrator has the discretionary authority to decide whether a charge is usual and reasonable.

PLAN EXCLUSIONS

Note: All exclusions related to prescription drugs are shown in the Prescription Drug section. For all benefits shown in the Schedule of Benefits, a charge for the following is not covered:

Prior Care. Payment will not be made for services or supplies provided to you before you become covered under the Jefferson County Health Plan.

Care Must be Medically Necessary. This Plan requires that the service or care you receive be medically necessary. Medically necessary care is care which, according to recognized criteria, is:

- Consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury;
- In accordance with generally accepted medical practices;
- Not solely for your convenience, or that of your doctor or other provider; and
- The most appropriate supply or level of service which can be safely provided to you.

Examples of unnecessary care are when you are admitted to a hospital for care which could have been provided in a doctor's office, or provided without admission to a hospital as a bed patient; when you are in a hospital longer than necessary to treat your condition; when hospitalized, you receive ancillary services not required to diagnose or treat your condition; when the care is provided in a more costly facility or setting than is necessary; or when a surgical procedure is performed when a medical treatment would have achieved the desired result.

In these situations, this Plan's determination of medical necessity will be made after considering the advice of trained medical professionals, which may include physicians, who will use medically recognized standards and criteria. In making the determination, the Third Party Administrator will examine all of the circumstances surrounding your condition and the care provided, including your doctor's reasons for providing or prescribing the care, and any unusual circumstances. However, the fact that your doctor prescribed the care does not automatically mean that the care qualifies for payments under this Plan.

The fact that a doctor may recommend that a covered person receive a surgical or medical services or be confined in a hospital does not mean:

- That such service or confinement will be deemed to be medically necessary, or
- That benefits under this Plan will be paid for the expense of such service or confinement.

The Third Party Administrator will make a decision as to whether such service or confinement is medically necessary in terms of generally accepted medical standards, and is qualified for benefits under this Plan.

Eye and Hearing Care. Except as outlined as covered, payment will not be made for eyeglasses, contact lenses or hearing aids and the examinations for the prescription or fitting of those items.

Cosmetic Surgery or Treatment. Payment will not be made for services in connection with elective cosmetic surgery which is primarily intended to improve your appearance. However, payment will be made for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the part of the body involved. For a child covered under this Plan, payment will also be made for reconstructive surgery because of congenital disease or anomaly (structural defects at birth) which has resulted in a functional defect.

Custodial Care. Payment will not be made for services rendered in connection with a hospital stay or portion of a hospital stay in connection with physical checkups, custodial or convalescent care, rest cures or

sanitarium-type care. Care is considered custodial when it's primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, and dressing, eating and taking medicine. Services or supplies rendered for convalescent care, custodial care, sanitarium type care, rest cures and services or supplies rendered in a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home or in an educational facility except as otherwise specifically covered under this Plan.

Workers' Compensation. Payment will not be made for care for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. Payments will not be made even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law. Also, payments will not be made even if you bring a lawsuit against the person who caused your injury or condition and even if you received money from that lawsuit and you have repaid hospital and other medical expenses you received payment for under the Workers' Compensation Law or similar legislation.

Government Facilities. Payment will not be made for services provided in a veteran's facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under this Plan were not in effect.

Government Coverage. Care, treatment or supplies furnished by a program or agency which are provided under any governmental program (other than Medicaid) under which you are or could be covered.

War. Services or supplies received as a result of an injury or sickness due to an act of war, whether declared or undeclared, or a warlike action in time of peace, which occurs after December 5, 1957.

No Charge. Payment will not be made for any care if the care is furnished or would normally be furnished to you without charge. You are not covered for services rendered by a Provider for which no legally enforceable charge is incurred.

Medicare. Payment will be reduced by the amount available to you under the Federal Government's Medicare program. When eligible, you must enroll in Medicare and file for all benefits available to you under Medicare.

No-Fault Automobile Insurance. Payment will not be made for any service which is covered by mandatory automobile No-Fault benefits. However, services not covered under No-Fault, such as when there is a deductible, will be covered by this Plan.

Experimental/Investigative Procedures. This Plan will not pay for services which are deemed experimental or investigative as determined by the Third Party Administrator with the advice of the State of New York in appropriate cases.

Medicines or Prescription Drugs.

Dental Services or Supplies Provided by a Dentist. However, you are covered for dental services and appliances necessary for the correction of damage caused by an accident provided the services are received within 12 months of the accident and while you are covered under this Plan. In addition, you are covered for oral surgery necessary for the correction of damage caused by an illness for which you are eligible for benefits under this Plan, and which occurs while you are covered under this Plan. Extractions, dental caries, periodontics (including but not limited to gingivitis, periodontitis and periodontosis) or the correction of impactions will not be covered.

Anesthesia. Services or supplies for the administration of anesthesia or the charges for surgery are not covered under this Plan.

Services or supplies to the extent they are not covered by the Hospital portion of this Plan due to noncompliance with the requirements of the Plan for inpatient admission, ambulatory surgery or for patient diagnostic testing.

Duplicative. Routine services which are duplicative because they are provided by both a midwife and a doctor.

Routine Foot Surgery. Services or supplies, including cutting or removal for treatment of corns, calluses or toenails, except care prescribed by a doctor while treating a metabolic disease.

Subrogation/Third Party Claim. Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement, other than from an insurance carrier under an individual policy issued to you.

Forms. Services rendered for medical summaries and medical invoice preparation.

PRESCRIPTION DRUG BENEFITS

This Plan will provide the prescription drug benefits described below:

Items Covered:

Legend Drugs - Drugs or compounds which require a prescription order and which are required by law to bear the legend “Caution - Federal Law Prohibits Dispensing without a Prescription”.

Prescription Orders - Drugs which are not legend drugs but which require a prescription order under New York State Law.

Other Prescriptions - Prescriptions which consist of two or more ingredients, at least one of which is a drug defined above.

Insulin - Use of the phrase prescription drugs in this booklet includes insulin.

All Drugs Prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives but excludes any drugs stated as not covered under this Plan.

Note: No copayment applies to FDA-approved contraceptives when prescribed by a physician for females with reproductive capacity up to age 50 to include brand and generic drug oral and injectable contraceptives, patches, and emergency contraceptives. Emergency contraceptives are only covered at the retail pharmacy. Benefits are not provided for abortifacient drugs. Over-the-counter (OTC) contraceptive drugs and devices are not covered.

Preventive Medications. The Plan will comply within one year of the effective date of all new recommendations or guideline changes as required under the federal Patient Protection and Affordable Care Act; the Plan will not cover any item or service that is no longer a recommended preventive service. No patient cost share is required for generic drugs mandated as covered under this provision. If a generic version is not available or would not be medically appropriate for the patient as determined by the attending physician, the brand name drug will be available at no cost share, subject to reasonable medical management approval by the Prescription Benefit Manager for the following:

Aspirin when prescribed by a physician, limited to males ages 45 years through 79 years to reduce risk of myocardial infarction and to females ages 55 years through 79 years to reduce risk of ischemic stroke.

Vitamin supplements when prescribed by a physician for OTC and prescription forms of folic acid for females to age 50 years who are planning or capable of a pregnancy; iron (ferrous sulphate) supplements to age one year for children who are at increased risk of iron deficiency anemia; and fluoride for children to age five years.

Smoking/tobacco use cessation agents when prescribed by a physician for covered persons over age 18 for over-the-counter and prescription forms to include gum, lozenge, patch, inhaler, nasal spray, and oral agents.

FDA-approved self-administered contraceptives when prescribed by a physician for females with reproductive capacity (up to age 50). Over-the-counter emergency contraceptives are only covered at the retail pharmacy. Benefits are not provided for abortifacient drugs or over the counter contraceptives obtained without a prescription other than emergency contraceptives as shown above.

Vitamin D2 or D3 containing 1,000IU or less per dosage form or combination vitamin D products that also contain calcium (combination of two agents only for the combination) when prescribed by a physician, limited to covered persons age 65 years or older.

When Payment Will Be Made. Payment will only be made when the drug is prescribed for your use outside of a hospital. A prescription order must be issued by one of the following except that a prescription order is not required for insulin:

- A Doctor of Medicine (M.D.)
- A Doctor of Osteopathy (D.O.)
- A Doctor of Dental Surgery (D.D.S.)
- A Doctor of Dental Medicine (D.M.D.)
- A Doctor of Podiatric Medicine (D.P.M.)

The doctor must be legally authorized to issue the prescription order. The prescription order must be filled by a licensed pharmacist in a retail pharmacy licensed by the state.

Amount of Payment. The amount of the payment depends on whether the prescription is filled:

- at an in-network pharmacy; or
- at an out-of-network pharmacy; or
- without showing your prescription drug card.

At an In-Network Pharmacy. An in-network pharmacy is one which has entered into an agreement with this Plan to provide prescription drug benefits under the Plan's prescription drug program. You must show your prescription drug card at the in-network pharmacy.

When you have a prescription filled at an in-network pharmacy, you must pay the pharmacy $5 for each separate prescription or refill for generic drugs, $15 for each separate prescription or refill for preferred brand drugs, $30 for each separate prescription or refill of non-preferred brand drugs or 20% of the cost for each separate prescription or refill of a specialty drug. The Plan will pay the pharmacy directly for the remainder of the cost of the prescription or refill.

Effective 1-1-2018
When you have a prescription filled at an in-network pharmacy, you must pay the pharmacy $10 for each separate prescription or refill for generic drugs, $20 for each separate prescription or refill for preferred brand drugs, $40 for each separate prescription or refill of non-preferred brand drugs, or 20% of the cost for each separate prescription or refill of a specialty drug. The Plan will pay the pharmacy directly for the remainder of the cost of the prescription or refill.

At an Out-of-Network-Network Pharmacy. An out-of-network pharmacy is one which is licensed by the state but which has not entered into an agreement with this Plan to provide benefits under this Plan.

If you have a prescription filled at an out-of-network pharmacy, this Plan will pay you the lesser of:

The pharmacy's actual charge for the prescription, minus $5 for generic drugs, $15 for preferred brand drugs, $30 for non-preferred brand drugs or 20% of the cost for each separate prescription or refill of a specialty drug.

The average cost for that drug in the area where the prescription is filled plus this Plan's dispensing fee ordinarily paid to in-network pharmacies in that area, minus $5 for generic drugs, $15 for preferred brand drugs, $30 for non-preferred brand drugs or 20% of the cost for each separate prescription or refill of a specialty drug. Payments for insulin will be the amount which this Plan determines is the usual and customary charge for insulin in that area, minus $5 for generic drugs, $15 for preferred brand drugs or $30 for non-preferred brand drugs.

Effective 1-1-2018

At an Out-of-Network-Network Pharmacy. *An out-of-network pharmacy is one which is licensed by the state but which has not entered into an agreement with this Plan to provide benefits under this Plan.*

If you have a prescription filled at an out-of-network pharmacy, this Plan will pay you the lesser of:

The pharmacy's actual charge for the prescription, minus $10 for generic drugs, $20 for preferred brand Drugs, $40 for non-preferred brand drugs or 20% of the cost for each separate prescription or refill of a specialty drug.

The average cost for that drug in the area where the prescription is filled plus this Plan's dispensing fee ordinarily paid to in-network pharmacies in that area, minus $10 for generic drugs, $20 for preferred brand drugs or $40 for non-preferred brand drugs or 20% of the cost for each separate prescription or refill of a specialty drug. Payments for insulin will be the amount which this Plan determines is the usual and customary charge for insulin in that area, minus $10 for generic drugs, $20 for preferred brand drugs or $40 for non-preferred brand drugs.

Without Showing Your Prescription Card. When you have your prescription order filled at an in-network pharmacy you must show your prescription drug identification card in order to receive the benefits. If you do not show your card, you will have to pay the pharmacy's charge. You must then submit the receipt and a claim form to the Pharmacy Benefit Manager and the payment will be the payment described above for out-of-network pharmacies.

Items Not Covered. No payment will be made for:

No Prescription. Drugs which do not require a written prescription order under federal or state law, except insulin.

Devices. Mechanical devices, such as artificial appliances and therapeutic devices.

Dietary/Vitamin Supplements. Vitamins, diet supplements or similar items.

Administration. Costs for administration or injection of drugs.

Experimental. Drugs classified under federal or state law as experimental.

Blood or blood plasma.

Inpatient Medication. Drugs dispensed while you are an inpatient in a nursing home or other institution, if the cost of the drug is billed by the institution.

Contrary to Normal Medical Practice. Drugs prescribed or dispensed in a manner which this Plan determines is contrary to normal medical practice.

Quantities, Refills and Generic Drugs

Quantity. Payment will be made for up to a 30 day consecutive supply of the drug. Prescription orders for chronic drugs will be dispensed in a supply for up to 90 consecutive days through a mail order program offered by the Prescription Benefit Manager or Third Party Administrator. A chronic drug is a drug such as an anti-arthritic, an anti-coagulant, an anticonvulsant, a cardiac drug or a hormone or thyroid preparation.

Refills. If the prescription order provides that it may be refilled, then payment will be made for up to five refills. If additional medication is necessary, a new prescription order or telephone authorization must be obtained.

Generic Drugs. Payment will not be made in an amount greater than the payment for an equivalent generic drug, unless the prescription order does not permit a generic equivalent to be substituted.

The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When your doctor prescribes a generic or authorizes a generic substitution, the pharmacy is permitted to dispense a generic drug.

When a generic drug is dispensed, your co-payment for each prescription or refill is $5.

Effective 1-1-2018
When a generic drug is dispensed, your co-payment for each prescription or refill is $10.

Maintenance Drug Program. Long term maintenance drugs will be provided on a mail order program for a three month supply with payment of one retail pharmacy payment for each prescription filled.

HOW TO SUBMIT A CLAIM

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

Network provider benefits are always paid directly to the network provider. Benefits for hospital or other facility are generally paid directly to the hospital or facility, if charges have not been paid by you. All other allowed charges/benefits are generally paid directly to you unless you direct payment to the Provider with written authorization. You may not assign your right to take legal action under this Plan to any provider of service.

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

When a covered person has a claim to submit for payment that person must:

Obtain a claim form from the Jefferson County Department of Insurance or the Third Party Administrator.

Complete the employee portion of the form. **ALL QUESTIONS MUST BE ANSWERED.**

Have the physician complete the provider's portion of the form.

For Plan reimbursements, attach bills for services rendered. All bills must show:

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

Send the above to the Third Party Administrator at the address listed on your ID card.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Plan Administrator within one year from the date of service. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless it's not reasonably possible to submit the claim in that time or when the person is not legally capable of submitting the claim.

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

COORDINATION OF BENEFITS

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

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

When this Plan is secondary, network benefits and network copayments will apply.

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

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

Allowable Fee. For a charge to be allowable it must be a usual and reasonable charge and at least part of it must be covered under this Plan.

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

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

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

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable fee, benefit payment will follow these rules. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

Plans with a coordination provision will pay their benefits up to the allowable fee:

The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

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

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

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

The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

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

This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.

If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare Part A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information

to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

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

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

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

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

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

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

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

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a covered person under the Plan.

MEDICARE

If Medicare is primary for you or your dependent, you must enroll in Part A and Part B. The benefits of the Plan will be integrated as follows:

Medicare Payment Integration. For Hospital benefits, this Plan will pay for the initial deductible in each spell of illness and the copayment amount for 61st – 90th day of hospital care in each spell of illness, which are not covered by Medicare. After 90 days of hospital care paid by Medicare, this Plan will pay for additional days in each spell of illness, until the Medicare and Plan combined total equals 365 days per spell of illness. Medicare Lifetime Reserve days may then be available. After Medicare hospital benefits are exhausted, this Plan's benefits will apply.

The Plan determines the allowable fee first, and then subtracts Medicare's payment from the allowable fee. Any difference will be subject to the Plan's usual benefit calculation for in-network or out-of-network benefits.

When this Plan is secondary, network benefits and network copayments will apply.

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

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

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

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

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

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

- If the provider accepts Medicare assignment of benefits, the allowable fees will be the same fees allowed by Medicare.

- If the provider does not accept Medicare assignment, the allowable fees will be based on the usual and reasonable charges for out-of-network providers, the network allowance for network providers or the charges determined by Medicare limiting charge regulations, whichever is the lower charge.

- If the provider provides services under a Medicare private contract option, allowable fees will be based on the usual and reasonable charges or the network allowance, if applicable, for services covered by this Plan.

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Administrator. The Jefferson County Health Benefits Program is the benefit plan of Jefferson County, the Plan Administrator, also called the Plan Sponsor.

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

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

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

Duties of the Plan Administrator:

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

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

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

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of Jefferson County and contributions made by the covered employees and retirees.

The level of any employee contributions will be set by the Plan Administrator, subject to the terms of any applicable collective bargaining agreement. These employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the employee or withheld from the employee's pay through payroll deduction. Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

Clerical Error

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

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

Misrepresentation/Fraud

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

Refund Due to Overpayment of Benefits

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

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

Amending and Terminating the Plan

If the Plan is terminated, the rights of the Plan participants are limited to expenses incurred before termination.

Jefferson County intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any), subject to the provisions of any applicable collective bargaining agreement.

Claims Appeal

In the event a claim has been denied, in whole or in part, you can request a review of your claim. This request for review should be sent to the Third Party Administrator at the address listed on your ID card within 60 days after you receive notice of denial of the claim. When requesting a review, please state the reason you believe the claim was improperly denied and submit any data, questions or comments you deem appropriate.

Federal Laws

This Plan shall be governed and construed according to Federal laws such as, but not limited to, the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Public Health Service Act, as applicable, and the Health Insurance Portability and Accountability Act, as amended. Federal laws will affect the provisions of this Plan only when directed at this type of self-funded health Plan for Plan Sponsors regulated by the laws. You may seek assistance or information about your rights under this plan by contacting the closest Employee Benefits Security Administration (EBSA), U.S. Department of Labor shown in your local phone directory or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

JEFFERSON COUNTY
HEALTH BENEFITS PROGRAM FOR
COUNTY EMPLOYEE AND DEPENDENT

DAVIS VISION
VISION CARE BENEFIT DESCRIPTION

APPENDIX 1

DAVISVISION®

SEE LIFE

Vision Care Plan Benefit Description

Sponsored by, and administered on behalf of the members and dependents of

Jefferson County

For information prior to enrolling visit Davis Vision's website at: **www.davisvision.com**, select the member option and enter client code **2484** or call **1.877.923.2847** (toll free).

Once enrolled, please visit Davis Vision's website: **www.davisvision.com**, or call **1.800.999.5431** with questions.

Jefferson County is pleased to provide this information about your vision care plan administered by Davis Vision, Inc., a leading national administrator of vision care programs. Eligibility for vision care benefits is determined by the same rules that apply to your health care benefits.

How do I receive services from a provider in the network?

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Davis Vision member and Jefferson County member or dependent.
- Provide the office with the member ID number and the name and date of birth of any covered dependent needing services.

It's that easy! The provider's office will verify your eligibility for services, and claim forms or ID cards are not required!

Who are the network providers?

They are licensed providers in both private practice and retail locations who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. Please access Davis Vision's website at **www.davisvision.com** and utilize the "Find a Doctor" feature, or call **1.800.999.5431** to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you.

What are the plan benefits, frequencies and costs?

EYE EXAMINATIONS ..... Every 12 months, including dilation as professionally indicated.

In-Network Copayment..... $20
Out-of-Network ..... Reimbursed up to $25

EYEGLASSES

Frame ..... Every 24 months
Spectacle Lenses ..... Every 12 months

In-Network Copayment
Frame $0
Spectacle Lenses $20

You may choose any Fashion, Designer or Premier level frame from Davis Vision's Frame Collection, covered in full. Or, if you select another frame in the network provider's office, a $14 credit, plus a 20% discount off any overage will be applied. This credit would also apply at retail locations that do not carry the Frame Collection. Members are responsible for the amount over $14 (less the applicable discount). For more information on lenses, please see "What lenses/coatings are included?"

Out-of-Network ....Reimbursed up to $25 for frames, up to $20 for single vision lenses, up to $30 for bifocals, up to $40 for trifocals.

CONTACT LENSES ..... Every 12 months
In-Network Copayment $25

In lieu of eyeglasses, you may select contact lenses. Any contact lenses from Davis Vision's Contact Lens Collection will be covered in full per the number indicated below, and your evaluation, fitting and follow up care will also be covered.

Davis Vision Premium Contact Lens Collection (includes evaluation, fitting, follow-up):
Disposable ..... Eight boxes/multi-packs
Planned Replacement ..... Four boxes/multi-packs

In lieu of the Davis Vision contact lenses, members may use their $45 credit, plus a 15% discount off any overage toward the provider's own supply of contact lenses, evaluation, fitting and follow-up care. For specialty contact lenses, a 15% discount is available for evaluation, fitting and follow-up care. This credit would also apply towards all contact lenses received at participating retail locations.

Medically necessary contact lenses will be covered in full with prior approval.

(CONTACT LENSES continued)
Out-of-Network .....Reimbursed up to $55 for elective contact lenses, up to $225 for medically necessary contact lenses with prior approval.

Please note: Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses. The Davis Vision collection is available at most participating independent provider locations.

What lenses/coatings are included?**

- Plastic single vision, bifocal or trifocal lenses, in any prescription range.
- Oversize lenses.
- Post-cataract lenses.
- Tinting of plastic lenses.
- Polycarbonate lenses.
- Scratch-resistant coating.
- Ultraviolet (UV) coating.
- Intermediate-vision lenses.
- Standard progressive addition multifocal lenses.***

Are there any optional frames, lens types or coatings available?**
Yes, you can pay the low, discounted fixed fees indicated (in addition to your basic copayment) and receive these exciting optional items:

- $20 for single vision scratch protection plan.
  Multifocal scratch protection plan is $40.
- $35 for standard ARC (anti-reflective coating). Premium ARC is $48. Ultra ARC is $60.
- $75 for polarized lenses.
- $65 for plastic photosensitive lenses.
- $55 for high-index (thinner and lighter) lenses.
- $40 for premium progressive addition multifocal lenses.***
- $90 for ultra progressive addition multifocal lenses.***

***These lens options and copays apply to in-network benefits only.*

**** Progressive addition multifocals can be worn by most people. Conventional bifocals will be supplied at no additional cost for anyone who is unable to adapt to progressive addition lenses; however, the copayment will not be refunded.*

When will I receive my eyewear?

Generally, your eyewear will be delivered to your provider from the laboratory within five business days. More delivery time may be needed when out-of-stock frames, anti-reflective coating, specialized prescriptions or a participating provider's frame is selected.

What about out-of-network provider benefits?

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Only one claim per service may be submitted for reimbursement each benefit cycle. To request claim forms, please visit the Davis Vision website at **www.davisvision.com** or call **1.800.999.5431.**

May I use the benefit at different times?

You may "split" your benefits by receiving your eye examination and eyeglasses (or contact lenses) on different dates or through different provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one provider. Continuity of care will best be maintained when all available services are obtained at one time from either a network or an out-of-network provider. To maximize your benefit value we recommend that all services be obtained from a network provider.

Information about Low Vision Services:

You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Up to four follow-up care visits will be covered during the five year period.

Information about Laser Vision Correction Services:

Davis Vision provides you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at discounts of up to 25% off a participating provider's normal charges, or 5% off any advertised special (please note that some providers have flat fees equivalent to these discounts). Please check the discount available to you with the participating provider. For more information, please visit us at www.davisvision.com or call 1.800.999.5431.

Mail Order Contact Lenses:

Free membership and access to a mail order replacement contact lens service, LENS123®, provides a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 1.800.LENS.123 (1.800.536.7123) or visit the LENS123® website at www.LENS123.com.

Warranty Information:

One-year eyeglass breakage warranty included at no additional cost. All plan eyeglasses come with a breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery. The warranty applies to all plan covered eyeglasses, i.e. spectacle lenses, Davis Vision Collection frames and national retailer frames (where our Exclusive Collection is not displayed).

Are there any exclusions?

The following items are not covered by this vision program:

- Medical treatment of eye disease or injury.
- Vision therapy.
- Special lens designs or coatings, other than those previously described.
- Replacement of lost eyewear.
- Non-prescription (plano) lenses.
- Contact lenses and eyeglasses in the same benefit cycle.
- Services not performed by licensed personnel.
- Two pairs of eyeglasses in lieu of a bifocal.

For more information, please visit Davis Vision's website at www.davisvision.com or call Davis Vision at 1.800.999.5431 to:

- Learn more about your benefits
- Locate a Davis Vision provider
- Verify eligibility
- Print an enrollment confirmation
- Request an out-of-network provider reimbursement form
- Contact a Member Service Representative

Member Service Representatives are available:

- Monday through Friday, 8:00 AM to 11:00 PM, Eastern Time
- Saturday, 9:00 AM to 4:00 PM, Eastern Time
- Sunday, 12:00 PM to 4:00 PM, Eastern Time

Participants who use a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services by calling 1-800-523-2847.

Your rights as a patient:

Davis Vision recognizes that all patients have specific rights, including, but not limited to:

- The right to complete information about their healthcare options and consequences.
- The right to participate in all treatment decisions.
- The right to dignity, privacy, confidentiality and non-discrimination.
- The right to complain or appeal any decision.

Patients also have the responsibility:

- To provide complete and accurate information.
- To follow care instructions.

For a complete copy of your Rights and Responsibilities as a Patient, please visit Davis Vision's website at: **www.davisvision.com** or call **1.800.999.5431.**

"All insured products are underwritten by either HM Life Insurance Company or HM Life Insurance Company of New York."

Davis Vision may operate as Davis Vision Insurance Administrators in California

JEFFERSON COUNTY
HEALTH BENEFITS PROGRAM FOR
COUNTY EMPLOYEES AND DEPENDENTS

Continuation Coverage Rights Under COBRA

Appendix 2

JEFFERSON COUNTY EMPLOYEES
HEALTH BENEFITS PROGRAM

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The Plan Administrator is Jefferson County. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

In addition to COBRA continuation of coverage, there may be other coverage options for Employees and their families:

- When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace.
- Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

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

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

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

(2) Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however,

an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

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

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

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

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

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

(1) The death of a covered Employee.

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

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

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

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

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

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

What Factors Should be Considered When Determining to Elect COBRA Continuation Coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law.

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

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

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

What is the Election Period and How Long Must it Last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

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

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

(2) death of the Employee,

(3) enrollment of the Employee in any part of Medicare.

IMPORTANT:

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

NOTICE PROCEDURES:

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

Jefferson County Insurance Department
175 Arsenal Street
Watertown, New York 13601
315.785.3043

If mailed, your notice must be postmarked no later than the last day of the required notice period.

Any notice you provide must state:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Must a Qualified Beneficiary be Given the Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan.

IF YOU HAVE QUESTIONS. If you have questions about your COBRA continuation coverage you should contact the COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll- free number at 1.866.444.3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

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

JEFFERSON COUNTY
HEALTH BENEFITS PROGRAM FOR
COUNTY EMPLOYEES AND DEPENDENTS

SCHEDULE OF BENEFITS
JANUARY 1, 2026

APPENDIX 3

Jefferson County Health Benefits Program
Schedule of Benefits January 1, 2026

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to the Health Benefits Program booklet.

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Hospital/Facility Deductible	Does not apply	Does not apply
Medical/Surgical Deductible per Calendar Year	Does not apply	Does not apply
Major Medical Deductible per Calendar Year	Does not apply	$600 Per Individual $1,200 Per Family
• **Common Accident Deductible**	Does not apply	Family $600 Cumulative for two or more covered family members injured in the same accident. Only expenses due to that accident and applied against the Plan deductible count toward this limit. Expenses also count toward the Calendar Year deductible.
• **Carry-over Individual Deductible**	Does not apply	Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year
• **Network Copayment, per visit Deputies**	$25 for certain Physician visits and outpatient services	$40 for certain Physician visits and outpatient services
	See individual plan features for details. "Per visit" means per Provider per day.	
	Copayments do not apply to the Out-of-Network deductible. Copayments do apply to the Out-of-Pocket Limit.	
• **Network Copayment, per visit All groups except Deputies**	$30 for certain Physician visits and outpatient services	$40 for certain Physician visits and outpatient services
	See individual plan features for details. "Per visit" means per Provider per day.	
	Copayments do not apply to the Out-of-Network deductible. Copayments do apply to the Out-of-Pocket Limit.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
• **Benefit Copayment, per visit All Agencies**	$100 for Emergency Room facility care	
• **Benefit Copayment, per stay All groups except Deputies**	$100 for Inpatient Hospital Facility	
Percentage Coinsurance (See individual plan features for details.) • **Hospital/Facility Benefits**	Plan pays 100% of the allowable network fee for covered services and supplies.	
• **Other Coinsurance**	Medical/Surgical Benefits: The Plan pays 100% of the allowable network fee for covered services and supplies after any applicable copayment.	Major Medical Benefits: The Plan pays 80% of the Usual, Reasonable and Customary charge (URC) for most covered services and supplies after application of the Major Medical deductible and any applicable copayment. The Covered Person pays the remaining 20%.
Medical/Surgical and Major Medical Out-of-Pocket (OOP) Limit, per Calendar Year	When copayment amounts reach the following maximums, no copayment will be required: $6,600 per individual $13,200 per family	Major Medical OOP: $1,350 *including copayments.* However, while copayment amounts apply to the OOP of $1,350, these copayments will continue to apply to services after the OOP is met. Deductible and Prescription Drug copayments are excluded.
Spell of Illness Limit	365 days per Spell of Illness (applies to Hospital inpatient care, including maternity admissions, Mental Health Disorders, Substance Use Disorders, Skilled Nursing Facility Care, Rehabilitation Facility Care, and Home Health Care)	
	A Spell of Illness begins when a Covered Person is admitted to a Hospital or other Covered Facility, Birthing Center, Skilled Nursing Facility, or Rehabilitation Facility or receives Home Health Care. It ends when the Covered Person has not been a patient in a Hospital or other Covered Facility, Birthing Center, Skilled Nursing Facility, or Rehabilitation Facility or received Home Health Care for a period of at least 90 days for the same illness.	
Maximum Benefit Amounts	Lifetime – Unlimited	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
	N/A	Major Medical Benefits per Calendar Year – Unlimited
Benefit Management Services Program/Pre-Notification	This mandatory program requires a phone call before the Covered Person is admitted to a Hospital, or before diagnostic testing is scheduled to be performed in an inpatient setting. Please contact UMR CARE toll-free at 1-866-494-4502. A benefit reduction will be applied for non-compliance with this requirement. Pre-certification is required for the following services: **(1) Inpatient admissions.** Inpatient Hospitalizations except emergency, urgent, and maternity stays Rehabilitation Facility inpatient stays Skilled Nursing Facility inpatient stays Substance Use Disorder/Mental Disorder inpatient admissions Notice of an emergency, urgent, or a maternity stay is requested to review Medical Necessity. **(2) Outpatient Diagnostic Testing Review.** Benefits may be reduced if diagnostic testing is rendered in an inpatient setting.	
☎ = If this Plan is primary, benefits with this symbol require precertification. Call UMR CARE at 1-866-494-4502. See the section entitled Benefit Management Services for details.		

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Acupuncture (based on Medical Necessity for pain relief or in lieu of anesthesia)	100% of the Allowable Fee after network copayment	80% of URC after deductible
Allergy Treatment	Visits and Treatment 100% of the Allowable Fee after a network copayment. Allergy Serum/Preparation Only 100% of the Allowable Fee, copayment does not apply	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	For allergy laboratory testing billed separately, see Diagnostic Testing.	
Ambulance • **Hospital**	100% of the Allowable Fee	100% of URC
Ambulance • **Professional**	100% of the Allowable Fee up to a limit of $50 maximum benefit per trip, then the balance is subject to Major Medical at 80% of URC after deductible.	100% of URC up to a limit of $50 maximum benefit per trip, then the balance is subject to Major Medical at 80% of URC after deductible.
Ambulance • **Volunteer**	100% up to $50 for trips under 50 miles or $75 for trips 50 miles and up.	100% up to $50 for trips under 50 miles or $75 for trips 50 miles and up. The deductible does not apply.
	Hospital, local professional, and volunteer ambulance, train, and air ambulance are covered.	
Ambulatory Surgical Center, Freestanding	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Anesthesia	100% of the Allowable Fee	80% of URC after deductible
	Coverage is also available for administration of anesthesia for non- surgical procedures when found Medically Necessary according to Plan provisions, for example, for covered electroshock therapy.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Biofeedback (based on Medical Necessity for certain medical disorders)	100% of the Allowable Fee	80% of URC after deductible
Blood and Blood Product Services	100% of the Allowable Fee	80% of URC after deductible
Cardiac Rehabilitation • **Freestanding Facility**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Cardiac Rehabilitation • **Outpatient Hospital**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Cardiac Rehabilitation • **Physician Office**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Chemotherapy • **Freestanding Facility**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Chemotherapy • **Outpatient Hospital**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
	Charges for oral chemotherapy and subcutaneous or intramuscular injections are payable as a Medical Surgical / Major Medical Benefit.	
Chemotherapy • **Physician Office**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Chiropractic Care (manipulation and related X-ray services)	100% of the Allowable Fee after network copayment per visit	80% of URC after deductible
	Subject to medical review; Maintenance Care is not covered.	
Clinical Trials • **Routine Patient Costs**	See specific service type for benefit.	Out-of-Network Providers will be allowed if an In-Network Provider will not accept the patient. See specific service type for benefit.
Consultation • **Inpatient**	100% of the Allowable Fee	80% of URC after deductible
	Limited to one inpatient consult per specialty per confinement for each condition	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Consultation • **Outpatient/Office**	100% of the Allowable Fee	80% of URC after deductible
	Limited to one inpatient consult per specialty per confinement for each condition	
Consultation • **Second Surgical – Voluntary**	100% of the Allowable Fee	80% of URC after deductible
Contact Lenses / Eyeglasses Following Intraocular / Cataract Surgery	100% of the Allowable Fee	80% of URC after deductible
	Benefit includes one pair of eyeglasses or contact lenses plus one exam following surgery.	
Dental Care, Limited	See Plan feature for details.	See Plan feature for details
	Benefits are available for limited oral surgical procedures and for treatment of accidental injury within 12 months of the accident.	
Diabetic Education	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Diabetic Supplies/Equipment	Not a separate benefit. Medically Necessary glucometers and insulin pumps are covered under the "Durable Medical Equipment" benefit. Syringes are covered under the "Medical Supplies (home use)" benefit or "Prescription Drug Benefits". Additional diabetic supplies are covered under your "Prescription Drug Benefits".	
Diagnostic Testing • Independent / Free Standing Laboratory	100% of the Allowable Fee after network copayment	80% of URC after deductible
Diagnostic Testing • Laboratory	100% of the Allowable Fee after network copayment	80% of URC after deductible
Outpatient Hospital (lab, machine, X-ray testing) • **Patient present in the outpatient department**	100% of the Allowable Fee after network copayment	100% of URC after network copayment

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Outpatient Hospital (lab, machine, X-ray testing) • **Patient *not* present in the outpatient department**	100% of the Allowable Fee after network copayment	100% of URC
Outpatient Hospital (lab, machine, X-ray testing) • **Professional Interpretation**	100% of the Allowable Fee	80% of URC
Outpatient Hospital (lab, machine, X-ray testing) • **X-ray**	100% of the Allowable Fee after network copayment	80% of URC
	☎ Benefits may be reduced if diagnostic testing is rendered in an inpatient setting.	
Outpatient Hospital (lab, machine, X-ray testing) • **X-ray**	100% of the Allowable Fee after network copayment	80% of URC
Dialysis • **Freestanding Facility** • **Outpatient Hospital** • **Physician Office**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Dietary / Nutritional Counseling other than Diabetes	Not Covered. See Preventive Care for wellness benefits	Not Covered. See Preventive Care for wellness benefits
Durable Medical Equipment	100% of the Allowable Fee	80% of URC after deductible
Oxygen	100% of the Allowable Fee	80% of URC after deductible
Breastfeeding Equipment (rental or purchase)	100% of the Allowable Fee	80% of URC after deductible
Electro-shock Therapy	100% of the Allowable Fee	80% of URC after deductible

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Food Products (Aminoacidopathies Formula, Enteral Formulas, Modified Solid Food Products)	100% of the Allowable Fee	80% of URC after deductible
Foot Care and Podiatry Services • **Visit**	100% of the Allowable Fee after network copayment	80% of URC after deductible
Foot Care and Podiatry Services • **Foot Orthotics**	100% of the Allowable Fee	80% of URC after deductible
	Orthotic devices for the feet are not covered unless used as conservative treatment for the back, hips, pelvis, ankle, knee, and legs.	
Foot Care and Podiatry Services • **Surgery**	100% of the Allowable Fee after network copayment	80% of URC after deductible
	Routine foot care is not covered. Exception: Routine foot care is covered for patients with severe systemic disorders, such as diabetes. Charges for orthopedic shoes and other supportive devices are not covered.	
Genetic Testing	See Diagnostic Testing for Benefit	
• **Related Genetic Counseling (see Preventive Care for wellness benefit.)**	100% of the Allowable Fee after network copayment	100% of URC after network copayment Deductible does not apply. Any balance that exceeds the URC is the responsibility of the Covered Member
Hearing Aid and Related Exam	100% of the Allowable Fee	100% of URC The deductible does not apply.
	Limited to $150 in any 36-month period.	
Home Health Care	100% of the Allowable Fee	100% of URC
	Three visits of HHC care count as one Benefit day toward the 365-day Spell of Illness limit. Medical/Surgical and Major Medical Benefits are available after this limit is reached. One HHC Visit equals • Up to four (4) hours of home health aid care; or • Each visit by other covered members of the HHC team. Services must be in lieu of Hospitalization or inpatient SNF care.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Hospice Care	100% of the Allowable Fee	100% of URC
	Benefits are payable for the period the Covered Person is accepted in the hospice care program. Bereavement counseling visits are covered for family members during the Covered Person's illness and until one year after the Covered Person's death.	
Hospital Facility • **Inpatient Hospital**	100% of the Allowable Fee after benefit copayment	100% of URC after benefit copayment
	Limited to 365 days per Spell of Illness. Medical/Surgical and Major Medical Benefits are available after this limit is reached.	
	☎ Room and Board charge limited to actual semi-private or ICU/specialty unit rate. The charge for a private room is based on the average semi-private room rate. A Medically Necessary private room is covered.	
Hospital Facility • **Outpatient Clinic**	100% of the Allowable Fee	100% of URC
	Clinic room only; related services are allowed per service type.	
Hospital Facility • **Emergency Room for Medical Emergency Condition**	For services rendered within 72 hours of an accident or 12 hours of a sudden onset of illness:	
	100% of the Allowable Fee after benefit copayment	100% of URC after benefit copayment
	Benefit copayment is waived if the Covered Person is admitted as an inpatient into the treating Hospital directly from the emergency room.	
Hospital Facility • **Emergency Room for non-Medical Emergency Condition**	Not Covered	Not Covered
Hospital Facility • **Outpatient Surgical Center**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Hospital Facility • **Other Outpatient Hospital Services and Supplies**	See specific service type for benefit.	
Infertility Services • **Basic Services**	See Plan feature for detail. Benefit is limited to the initial evaluation and testing for Infertility.	
Infertility Services • **Advanced Services**	See Plan feature for detail. Benefit is limited to the initial evaluation and testing for Infertility.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
In-Hospital / Facility Physician's Care	100% of the Allowable Fee	80% of URC after deductible
	Coverage is only provided for visits for days approved for a covered inpatient stay.	
IV (Infusion) Therapy • **Outpatient Hospital**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
	See also Home Health Care.	
IV (Infusion) Therapy • **Office**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
	See also Home Health Care.	
Maternity Care • **Inpatient Hospital and Certified Birthing Centers**	100% of the Allowable Fee	100% of URC
	Limited to 365 days per Spell of Illness. Medical/Surgical and Major Medical Benefits are available after this limit is reached.	
	☎ Room and Board charge limited to actual semi-private or ICU/specialty unit rate. The charge for a private room is based on the average semi-private room rate. A Medically Necessary private room is covered.	
	Maternity is covered the same as any other Illness.	
Maternity Care • **Prenatal, Delivery, and Postpartum Care of Normal Pregnancy, Physician Charge (Physician / Midwife)**	100% of the Allowable Fee	80% of URC after deductible
	Related testing is covered separately per service type rendered.	
Maternity Care • **Complications of Pregnancy and Termination of Pregnancy, Physician Charge**	100% of the Allowable Fee	80% of URC after deductible
	Related testing is covered separately per service type rendered.	
Medical / Surgical Supplies	100% of the Allowable Fee	80% of URC after deductible
Mental Disorder Treatment • **Inpatient** • **General Hospital, Private Proprietary or Public Psychiatric Facility** • **Hospital Mental Disorder Partial Hospitalization**	100% of the Allowable Fee	100% of URC
	☎ Limited to 365-day limit per spell of illness (applies toward the inpatient Hospital Spell of Illness maximum) Medical/Surgical and Major Medical Benefits are available after this limit is reached. Room and Board charge limited to actual semi-private or ICU/specialty unit rate. The charge for a private room is based on the average semi-private room rate. A Medically Necessary private room is covered.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Mental Disorder Treatment • **Inpatient, Physician Charge**	100% of the Allowable Fee	80% of URC after deductible
Mental Disorder Treatment • **Outpatient / Office**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	Services must be rendered and billed by a New York State licensed mental health professional performing services within the scope of their license (doctor, psychologist, social worker). For services rendered and billed outside of New York State the Provider must be operating within the scope of their license and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health facility, Physician's corporation, or clinic for the services of a similarly licensed Provider will also be covered. Family therapy is covered.	
Mental Disorder Treatment • **Psychological Testing**	100% of the Allowable Fee after a network copayment	80% of URC after deductible
Newborn Care • **Circumcision**	100% of the Allowable Fee	100% of URC The deductible does not apply.
Newborn Care • **Hospital**	See Hospital / Birthing Center	
Newborn Care • **Physician**	100% of the Allowable Fee	100% of URC The deductible does not apply.
	Limited to Allowed Charges made by a Physician for routine pediatric care after birth while the newborn child is Hospital-confined up to four days. If the baby's routine care is extended due to the mother's continued stay, benefits will not be paid even if the mother was needed to provide basic care, such as breastfeeding. Routine newborn care billed by an anesthesiologist or the delivering Physician is not covered.	
Nursing, Private Duty • **Inpatient**	Not Covered	Not Covered

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Nursing, Private Duty • **Outpatient**	100% of the Allowable Fee	60% of URC after deductible
	The first 48 hours of nursing care in a Calendar Year are not covered. Limited to $25,000 per Calendar Year; this limit may be waived, subject to medical review.	
Visiting Nurses	100% of the Allowable Fee	100% of URC
	Part-Time or Intermittent Care is Covered.	
	Charges are covered only when care is Medically Necessary and not Custodial in nature. The charges covered for outpatient nursing care are those shown billed by a certified or licensed visiting nurse agency or by a state or county visiting nurse service for professional nurse services. Outpatient private duty nursing care on a 24-hour-shift basis is not covered	
Obesity, Morbid Treatment	Benefits are based on service type rendered. Medically Necessary (as determined by the Claims Administrator) weight reduction surgery is limited to gastric bypass and lap band procedures. Non-surgical charges for Morbid Obesity will be covered; however, charges for dietary/nutritional counseling are excluded.	
Occupational Therapy • **Freestanding Facility**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Occupational Therapy • **Outpatient Hospital**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Occupational Therapy • **Physician Office**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Orthotics	100% of the Allowable Fee	80% of URC after deductible
Osteopathic Manipulation	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Physical Therapy • **Freestanding Facility**	100% of the Allowable Fee after network copayment	100% of URC after network copayment

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Physical Therapy • **Outpatient Hospital**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
	Treatment must begin within six months and end within 365 days of the date of a related Hospital discharge or date of surgery.	
Physical Therapy • **Office**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
	Maintenance Care is not covered.	
Physician Care • **Emergency Room** • **Medical Emergency**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	Benefit copayment applies if the Covered Person is admitted as an inpatient into the treating Hospital directly from the emergency room.	
Physician Care • **Emergency Room** • **Non-Medical Emergency**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Physician Care • **Office or Home**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Physician Care • **Clinic**	100% of the Allowable Fee after a network copayment	80% of URC after deductible
	Services must be given and billed by a covered healthcare Provider and found Medically Necessary according to Plan provisions in an office, clinic, home, or elsewhere. Outpatient Mental Health Disorder care, outpatient Substance Use Disorder care, outpatient consultations, surgical and obstetrical procedures, rehabilitation therapy, preventive care, and chiropractic care are not covered under this benefit.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Preadmission Testing	100% of the Allowable Fee after network copayment	100% of URC after network copayment
	Must be: • Performed on an outpatient basis within 14 days before a scheduled Hospital surgery; • Your Physician ordered the tests; and • Physically present at the Hospital for the tests. Covered Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.	
Prescription Drugs	See the separate Prescription Drug Expense Benefit (ProAct) below.	
Preventive Care (Includes all Ancillary Charges) • **Routine Adult Physical (from Age 19)**	If a Network Provider is not available, the Plan will benefit 100% of charges and the deductible will not apply.	
	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	The recommendations of the United States Preventive Services Task Force will apply to exams and screening tests; the recommendations of the Advisory Committee on Immunization Practices (ACIP) will apply to immunizations.	Benefit includes routine exam and related screening tests follows the recommendations of the U.S. Preventive Services Task Force. Immunizations: the administration of the vaccine is covered; the charge for the vaccine is excluded.
Preventive Care (Includes all Ancillary Charges) • **Mammography Screening**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Preventive Care (Includes all Ancillary Charges) • **Bone Density Testing**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Preventive Care (Includes all Ancillary Charges) • **Cervical Cancer Screening**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Preventive Care (Includes all Ancillary Charges) • **Prostate Cancer Screening**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Preventive Care (Includes all Ancillary Charges) • **Colorectal Cancer Screening**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Preventive Care (Includes all Ancillary Charges) • **Genetic Counseling / Testing (related to BRCA mutation genetic screening for breast and ovarian cancer)**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	The recommendations of the U.S. Preventive Services Task Force apply.	
Preventive Care (Includes all Ancillary Charges) • **Smoking / Tobacco Use Cessation Counseling**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	The recommendations of the U.S. Preventive Services Task Force apply. Smoking cessation drugs are covered under the Prescription Drug Benefit.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Preventive Care (Includes all Ancillary Charges) • **Nutritional Counseling (for adults with risk factors and both adults and children with obesity)**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	Limited to 26 wellness visits (no more frequently than one visit every two weeks) per Covered Person per Calendar Year combined In-Network and Out-of-Network.	
Preventive Care (Includes all Ancillary Charges) • **Well-Woman Services not otherwise specified**	Women's preventive services under the Affordable Care Act include, but are not limited to, coverage for screening, counseling, and contraception methods; see the Preventive Care section in the SPD for details.	
Preventive Care (Includes all Ancillary Charges) • **HPV-DNA Testing**	100% of the Allowable Fee	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Preventive Care (Includes all Ancillary Charges) • **Contraception Management**	100% of the Allowable Fee	100% of URC after a network copayment
Preventive Care (Includes all Ancillary Charges) • **Screening for Gestational Diabetes**	100% of the Allowable Fee	80% of URC after deductible
Preventive Care (Includes all Ancillary Charges) • **Breastfeeding Equipment (rental or purchase)**	100% of the Allowable Fee	80% of URC after deductible

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Preventive Care (Includes all Ancillary Charges) • **Well Child Care (up to Age 19)**	100% of the Allowable Fee	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	Coverage for health care visits and related testing follows the recommendations of the U.S. Preventive Services Task Force; the recommendations of the Advisory Committee on Immunization Practices (ACIP) will apply to immunizations. Routine newborn care is covered as shown above.	Immunizations: the administration of the vaccine is covered; the charge for the vaccine is excluded. Coverage for health care visits and related testing follows the recommendations of the U.S. Preventive Services Task Force. Routine newborn care is covered as shown above.
Prosthetics	100% of the Allowable Fee	80% of URC after deductible
Pulmonary Rehabilitation • **Freestanding Facility**	100% of the Allowable Fee	80% of URC after deductible
Pulmonary Rehabilitation • **Freestanding Facility**	100% of the Allowable Fee	80% of URC after deductible
Physician Office	100% of the Allowable Fee	80% of URC after deductible
	Coverage is limited to a maximum of 36 visits per Covered Person per Lifetime for an approved plan of care. Related testing procedures will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits.	
PUVA (Psoralen & Ultraviolet Radiation Light Therapy)	100% of the Allowable Fee	80% of URC after deductible
Radiation Therapy • **Freestanding Facility**	100% of the Allowable Fee	80% of URC after deductible
Radiation Therapy • **Outpatient Facility**	100% of the Allowable Fee after network copayment	100% of URC after network copayment

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Radiation Therapy • **Office**	100% of the Allowable Fee	80% of URC after deductible
Refractive Surgery	Not Covered	Not Covered
Rehabilitation Facility • **Inpatient Services**	100% of the Allowable Fee	100% of URC
	☎ Limited to 365-day limit per Spell of Illness (applies toward the inpatient Hospital Spell of Illness maximum). Two days of care count as one Benefit day. Medical/Surgical and Major Medical Benefits are available after this limit is reached. Room and Board charge limited to actual semi-private or ICU/specialty unit rate. The charge for a private room is based on the average semi- private room rate. A Medically Necessary private room is covered. If the facility qualifies as a SNF, benefits are not available if Medicare is primary or if Medicare benefits for skilled nursing facility care are exhausted.	
Rehabilitation Facility • **Outpatient Services**	See specific service type for benefit. For example, benefits for outpatient services are the same as the benefits for outpatient Hospital diagnostic X-ray, laboratory, pathology, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, radiation therapy, and inhalation therapy services shown in this section.	
Respiratory Therapy • **Freestanding Facility**	100% of the Allowable Fee	80% of URC after deductible
Respiratory Therapy • **Outpatient Hospital**	100% of the Allowable Fee	80% of URC after deductible
Respiratory Therapy • **Physician Office**	100% of the Allowable Fee	80% of URC after deductible

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Skilled Nursing Facility • **Inpatient Services**	100% of the Allowable Fee	100% of URC
	 Limited to 365-day limit per Spell of Illness (applies toward the inpatient Hospital Spell of Illness maximum). Two days of SNF care count as one Benefit day. Medical/Surgical and Major Medical Benefits are available after this limit is reached. Room and Board charge limited to actual semi-private or specialty unit rate. The charge for a private room is based on the average semi- private room rate. A Medically Necessary private room is covered. Benefits are not available if Medicare is primary or if Medicare benefits for skilled nursing facility care are exhausted.	
Skilled Nursing Facility • **Outpatient Services**	See specific service type for benefit. For example, benefits for outpatient SNF are the same as the benefits for outpatient Hospital diagnostic Xray, laboratory, pathology, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, radiation therapy, and inhalation therapy services shown in this section.	
Smoking Cessation	See Preventive Care.	
Speech Therapy • **Freestanding Facility**	100% of the Allowable Fee	80% of URC after deductible
Speech Therapy • **Outpatient Hospital**	100% of the Allowable Fee	80% of URC after deductible
Speech Therapy • **Physician Office**	100% of the Allowable Fee	80% of URC after deductible
Substance Use Disorder Detoxification / Rehabilitation Treatment • **Inpatient Facility** • **General Hospital or Certified Alcohol / Substance Use Disorder Facility Program** • **Hospital Substance Use Disorder Day / Night Care Center**	100% of the Allowable Fee	100% of URC
	 100% for up to 365 days per Spell of Illness. Limited to 365-day limit per Spell of Illness (applies toward the inpatient Hospital Spell of Illness maximum). Medical/Surgical and Major Medical Benefits are available after this limit is reached. Room and Board charge limited to actual semi-private or ICU/specialty unit rate. The charge for a private room is based on the average semiprivate room rate. A Medically Necessary private room is covered.	

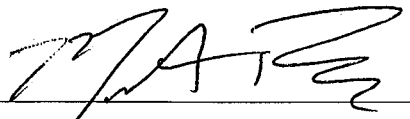
Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Substance Use Disorder Detoxification / Rehabilitation Treatment • **Inpatient Physician**	100% of the Allowable Fee	80% of URC after deductible
Substance Use Disorder Detoxification / Rehabilitation Treatment • **Outpatient / Office**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	Family Therapy is covered.	
Surgical Charge Benefit • **Assistant Surgeon**	100% of the Allowable Fee	80% of URC after deductible
Surgical Charge Benefit • **Surgeon** ○ **Inpatient**	100% of the Allowable Fee	80% of URC after deductible
Surgical Charge Benefit • **Surgeon** ○ **Office**	100% of the Allowable Fee	80% of URC after deductible
Surgical Charge Benefit • **Surgeon** ○ **Outpatient**	100% of the Allowable Fee	80% of URC after deductible
	Breast biopsy Bronchoscopy Colonoscopy D&C – diagnostic Excision of skin lesion	Gastroscopy Laparoscopy - diagnostic Myringotomy Vasectomy
	Outpatient: 100% of the Allowable Fee	Outpatient: 100% of URC after deductible
	Inpatient: 100% of the Allowable Fee	Inpatient: 800% of URC after deductible
Therapeutic Injections	100% of the Allowable Fee after network copayment	100% of URC after network copayment
TMJ (temporomandibular joint) Treatment	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Transplants – Organ / Tissue	Covered See Plan features for detail.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Urgent Care Facility	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Vision Care	Scheduled benefits for routine vision exams and lenses are offered through the Davis Vision Care Program.	
Vision Therapy (based on Medical Necessity)	100% of the Allowable Fee	80% of URC after deductible
Voluntary or Elective Abortion	Covered- See Plan feature for detail.	Covered- See Plan feature for detail.
Voluntary or Elective Sterilization Procedure	Covered- See Plan feature for detail.	Covered- See Plan feature for detail.
Wigs	Not Covered	Not Covered

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits

Prescription Drug Benefits		
Prescription Drug Benefits" are generally separate from "Medical Benefits" and do not apply to the deductibles, copayments, or Out-of-Pocket limits for Medical Benefits.		
Any one retail Pharmacy prescription or refill is limited to a 90-day supply. Any one mail order prescription or refill is limited to a 90-day supply		
Covered Drugs and Supplies	**In-Network and Out-of-Network**	
Prescription Drug Benefit (ProAct) **Deputies**	**Note:** You must pay applicable copayments*. The Plan pays the balance of Allowable Fees.	
	Copayments Per Prescription	
	Retail	**Mail-Order**
Generic (Tier 1)	$15.00	$15.00
Preferred Brand (Tier 2)	$30.00	$30.00
Non-Preferred Brand (Tier 3)	$50.00	$50.00
Specialty Drugs (Tier 4)	20%	20%
Prescription Drug Benefit (ProAct) **All groups except Deputies**	**Note:** You must pay applicable copayments*. The Plan pays the balance of Allowable Fees.	
	Copayments Per Prescription	
	Retail	**Mail-Order**
Generic (Tier 1)	$15.00	$30.00
Preferred Brand (Tier 2)	$30.00	$60.00
Non-Preferred Brand (Tier 3)	$50.00	$100.00
Specialty Drugs (Tier 4)	20%	20%
Out-of-Pocket Limit	In-Network copayments apply to the Medical/Surgical and Major Medical Out-of-Pocket Limit.	
*The Plan will follow the federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. Contact ProAct's Customer Service Department toll-free at 1-866-287-9885 for details on medications which do not require a copayment; for example, no copayment applies to certain prescription contraceptives, aspirin, folic acid, fluoride, iron, smoking cessation agents, and Vitamin D.		

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits

No patient cost share is required for Generic drugs mandated as covered under this provision. If a Generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval.	
IN WITNESS WHEREOF this agreement has been executed on behalf of Jefferson County Employees Health Benefits Program.	
By:	
Title:	Director of Insurance
Date:	9/30/2025