SKIDMORE COLLEGE

EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT

EFFECTIVE JANUARY 1, 2011

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SCHEDULE OF MEDICAL BENEFITS			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
Co-pay	$15	Not applicable	
Individual Inpatient Hospital Co-pay	$200	Not applicable	The co-pay will not apply if re-admitted within 90 days.
Family Inpatient Hospital Co-pay	$500	Not applicable	
Individual Deductible	Not applicable	$200	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	Not applicable	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	Not applicable	$1,500	Includes out-of-network deductible and coinsurance. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	Not applicable	$3,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise.			

Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Allergy Testing & Injections	100%	80%*	Co-pay taken when billed with an office visit.
Alternative Health Care	100%	100%	Limited to a maximum of $300 per family per calendar year. Includes acupuncture, fitness center membership, fitness classes, yoga, homeopathic, hypnotherapy, massage therapy, nutritional counseling and weight control programs. Products purchased through these programs are excluded. Eff. 5/1/11: Child birth classes are included.
Ambulance - Ground / Air	100% after $50 co-pay	100% after $50 co-pay	
Ambulette (Wheelchair Vans / Stretcher Vans)	100% after $50 co-pay	80%*	
Anesthesia	100%	80%*	Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
*Deductible applies			

Medical Plan	In-Network	Out-of-Network	Limitations and Explanations
Artificial Insemination & Infertility Services	100%	80%*	Limited to $10,000 per family per calendar year. Includes, but is not limited to, artificial insemination, embryo transplant, sperm processing and in-vitro.
Cardiac Rehabilitation	100% after $15 co-pay	80%*	Applicable to treatment after an acute heart condition. Limited to 24 visits in a 12 week period.
Chemotherapy / Radiation Therapy	100% after $15 co-pay	80%*	
Chiropractic Care	100% after $15 co-pay	80%*	
Diabetic Education	100% after $15 co-pay	80%*	
Diabetic Equipment & Supplies	100% after $15 co-pay	80%*	Co-pay applies per item.
Diagnostic Laboratory Services - Outpatient	100%	80%*	Out-of-network routine services are not covered.
Diagnostic MRI / MRA / PET / CT	100%	80%*	Prior authorization is required for participating providers. Out-of-network providers are subject to review for medical necessity.
Diagnostic X-Ray	100%	80%*	
Dialysis	100% after $15 co-pay	80%*	
Durable Medical Equipment	100%	80%*	Prior authorization is required for some equipment.
Flu Vaccination	100% after $15 co-pay	80%*	
Home Health Care	100% after $15 co-pay	80%*	Prior authorization is required, except for home infusion therapy. Limited to 200 visits per calendar year.
Hospice Care	100%	80%*	Prior authorization is required for inpatient. Includes bereavement counseling.
Hospital - Emergency Room	100% after $50 co-pay	100% after $50 co-pay	The co-pay is waived if the patient is admitted. Non-emergent use of the emergency room is not covered.
Hospital - Inpatient	100% after applicable co-pay	80%*	Prior authorization is required.
Hospital - Inpatient Acute Physical Rehabilitation Facility	100% after applicable co-pay	80%*	Prior authorization is required. Limited to 60 days per calendar year.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $15 co-pay	80%*	Prior authorization is required for some procedures.
*Deductible applies			

Medical Plan	In-Network	Out-of-Network	Limitations and Explanations
Hospital - Pre-Admission Testing	100%	80%*	Should be performed within 7 days prior to admission.
Hospital - Urgent Care Center	100% after $25 co-pay	100% after $25 co-pay	
Hospital - All Other Outpatient Services	100%	80%*	
Infusion Therapy	100%	80%*	
Medical Supplies	100%	80%*	Includes, but not limited to, syringes, colostomy supplies and IUDs.
Orthotics & External Prosthetics	80%*	50%*	Prior authorization is required for some items. Footwear is not covered. Prosthetic coverage includes repairs but not replacement, except for individuals under age 19. Eff. 6/1/11: Orthotic devices are covered when prescribed by a physician.
Physician Visit - Emergency Room	100%	100%	
Physician Visit - Office / Clinic / Home	100% after $15 co-pay	80%*	
Physician Visit - Inpatient	100%	80%*	
Physician - Inpatient Surgeon	100%	80%*	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	
Physician - Office Surgeon	100% after $15 co-pay	80%*	
Physician - Assistant Surgeon	100%	80%*	Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
Post-Mastectomy Prosthetic	100%	80%*	Prior authorization is required. Limited to 1 per affected breast in any 2 calendar years.
Post-Mastectomy Surgical Bra	100%	80%*	Prior authorization is required. Limited to 4 per calendar year.
Preventive Care - Routine Gynecologic Examination	100% after $15 co-pay	80%*	Limited to 2 examinations per calendar year.
Preventive Care - Routine Mammogram	100%	80%*	Limited to 1 baseline mammogram from age 35 through 39; 1 routine mammogram each calendar year thereafter.
Preventive Care - Routine PAP Smear	100%	80%*	
*Deductible applies			

Medical Plan	In-Network	Out-of-Network	Limitations and Explanations
Preventive Care - Routine Colonoscopy	100%	80%*	This benefit is effective 5/1/11. Limited to individuals age 50 and older.
Preventive Care - Routine Physical (Age 19 and older)	100% after $15 co-pay	Not covered	Eligible expenses include routine physical examination limited to 1 per calendar year, related routine laboratory and x-ray testing, prostate screening, hearing examination and immunizations.
Preventive Care - Well Child Care (Birth to Age 19)	100%	80%*	Eligible expenses include routine physical examination, related routine laboratory and x-ray testing, hearing examination and immunizations.
Rehabilitative Therapy - Physical / Occupational / Speech	100% after $15 co-pay	80%*	Limited to an aggregate of 80 visits per calendar year.
Rehabilitative Therapy - Pulmonary	100%	80%*	
Rehabilitative Therapy - Respiratory	100%	80%*	
Skilled Nursing Facility	100% after applicable co-pay	80%*	Prior authorization is required. Limited to 120 days per calendar year. Admission must follow a minimum 3-day stay in a hospital and admittance must occur within 10 days of hospital discharge.
Sleep Studies	100% after $15 co-pay	80%*	
Transfusion	100% after $15 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF VISION BENEFITS			
Vision Plan	**In-Network**	**Out-Of-Network**	**Limitations and Explanations**
Eye Examination/ Refraction	100% after $15 co-pay	80%*	Limited to 1 routine eye examination every 2 years.
Frames/Lenses/ Contact Lenses	100%	100%	Limited to a maximum of $150 every 2 years.
*Medical deductible applies			

INTRODUCTION

Skidmore College has prepared this document to help you understand your benefits. **PLEASE READ IT CAREFULLY AS YOUR BENEFITS ARE AFFECTED BY CERTAIN LIMITATIONS AND CONDITIONS.** Also, benefits are not provided for certain kinds of treatments or services, even if your *health care provider* recommends them.

This Plan provides benefits only for covered expenses; payment is based on the lesser of actual charges or the applicable schedules of allowance. However, any amounts you are obligated to pay in excess of the amount listed in our *Schedule of Allowances* or in excess of any dollar limitation on benefits will not be counted in determining when you, or a member of your family, have reached the maximum payments in a *plan year*. In addition, you will remain responsible for all charges in excess of the amount listed in the applicable *Schedule of Allowances* even after the thresholds are met.

This document is written in simple, easy-to-understand language. Technical terms are printed in italics and defined in the Definitions section. The headings in the Plan are inserted for convenience of reference only and are not to be construed or used to interpret any of the provisions of the Plan.

As used in this document, the word *year* refers to the *calendar year* which is the twelve (12) month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *calendar year*. The word *lifetime* as used in this document refers to the period of time a covered person is a participant in this Plan sponsored by Skidmore College

Benefits described in this document are effective January 1, 2011. The terms and conditions of the Skidmore College Employee Benefit Plan are governed by the provisions in this document. Any and all other written communication regarding the Plan or the benefits provided under the Plan are superseded and are of no force or effect.

This Plan is in compliance with all applicable federal laws. In the event of a change in federal law, the Plan will be deemed to be in compliance and administered accordingly.

ARTICLE I -- ELIGIBILITY AND PARTICIPATION

A. Who Is Eligible

You are eligible to participate in this Plan if you are:

1. a regularly scheduled full-time employee of the company who works a minimum of thirty-five (35) hours per week;

2. a regularly scheduled part-time employee of the company who works a minimum of 1,365 hours per year in a 12-month position;

3. a part-time employee of the company who has one (1) year or more of service and works less than 1,365 hours per year;

4. a part-time employee that is in an approved shared position; or

5. a *retiree* of the company.

Your eligible dependents may also participate. Eligible dependents include:

1. A legal *spouse*, unless legally separated from you.

2. A same or opposite sex domestic partner. An employee and domestic partner must certify their relationship by completing an affidavit of domestic partnership.

3. A child from birth to age twenty-six (26).

The term child includes:

   a. a natural child;

   b. a step-child by legal marriage;

   c. a child who is adopted or has been placed with you for adoption by a court of competent jurisdiction;

   d. a child for whom legal guardianship has been awarded;

   e. a child who is the subject of a *Qualified Medical Child Support Order* (QMCSO) dated on or after August 10, 1993. To be "qualified," a state court medical child support order must specify: the name and last known mailing address of the Plan participant and each alternate recipient covered by the order, a reasonable description of the type of coverage or benefit to be provided to the alternate recipient, the period to which the medical child support order applies, and each plan to which the order applies; and

f. a child who is incapable of self-sustaining employment by reason of mental or physical disability may continue to be covered under this Plan regardless of age, so long as the disability persists, and the disability began before the child reached age twenty-six (26). In order to continue coverage, you must furnish written proof of the disability within thirty-one (31) days of the child's twenty-sixth (26^{th}) birthday. The *Plan Administrator* may require you to furnish periodic proof of the child's continued disability but not more often than annually after the child's twenty-sixth (26^{th}) birthday. If such proof is not satisfactory to the *Plan Administrator*, coverage for the child will end immediately.

You may not participate in this Plan as an employee and as a dependent. In addition, a person may not participate in this Plan as a dependent of more than one (1) employee.

No one who is on active duty with the armed forces will be eligible for coverage under this Plan.

B. Who Pays For Your Benefits

Skidmore College shares the cost of providing benefits for you and your dependents.

C. Enrollment Requirements

If you desire Plan benefits, you must enroll in the Plan by properly completing and returning an enrollment form to Skidmore College within thirty-one (31) days of your eligibility date. If you are an active, full-time employee also desiring dependent coverage, you must enroll your eligible dependents by this deadline. If you do not have any eligible dependents at the time of initial enrollment but acquire eligible dependents at a later date, you must enroll dependents, including newborns, by properly completing and returning an enrollment form to Skidmore College within thirty-one (31) days of the date they become your dependent(s).

Failure to enroll by the deadline noted above will subject you and your dependents to the Late Enrollment, or Special Enrollment Period provisions below.

D. Late Enrollment

If an eligible employee or dependent declined coverage at the time initially eligible, coverage cannot become effective until the next annual *open enrollment period* unless application for coverage was due to a Special Enrollment as defined under the Special Enrollment Period provision below. The employee or dependent must request enrollment in this Plan within the *open enrollment period.* This provision does not apply to a dependent who becomes eligible for coverage as the result of a *Qualified Medical Child Support Order*, or who is adopted or is placed with you for adoption by a court of competent jurisdiction, as long as he is enrolled within thirty-one (31) days of his eligibility date.

The *enrollment date* for a *late enrollee* is the first day of coverage. Thus, the time between the date a *late enrollee* first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a *waiting period*.

E. Special Enrollment Periods

The *enrollment date* for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a *special enrollee* first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a *waiting period*. Special Enrollment Periods apply to the following:

1. Individuals losing other coverage. An employee or dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

    a. The employee or dependent was covered under a group health plan, Medicaid including coverage under state funded Children's Health Insurance Plan (CHIP) or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

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

    c. The coverage of the employee or dependent who has 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 employer contributions toward the coverage were terminated.

    d. The employee requests enrollment in this Plan not later than:

        i. thirty-one (31) days following the termination of coverage or employer contributions, as described above;
        ii. thirty-one (31) days following the date COBRA coverage was exhausted;
        iii. sixty (60) days following the termination of Medicaid or CHIP.

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

2. Dependent beneficiaries. If:

   a. The employee is a participant under this Plan (or has met the *waiting period* applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

   b. 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 employee. In the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent of the employee if the spouse is otherwise eligible for coverage.

      The dependent Special Enrollment Period is a period of thirty-one (31) days and begins on the date of the marriage, birth, adoption or placement for adoption.

3. *Transitional rule dependent* beneficiaries single or married who are under the age of twenty-six (26) are eligible to enroll in the Plan if either of the following conditions are met:

   a. The dependent beneficiary was previously enrolled in the Plan and their eligibility was terminated due to age; or

   b. The dependent beneficiary was previously not eligible under the Plan when the employee first became eligible as their age at that time exceeded the Plan limitation.

   If a dependent beneficiary is under the age of twenty-six (26) and eligible for other employer sponsored health coverage, they may not waive the available employer sponsored coverage in order to enroll under this Plan.

4. Coverage for a *special enrollee*, as stated above in Section 1., shall begin on the day following the loss of coverage. Coverage for a *special enrollee*, as stated above in Section 2., shall begin as of the date of the marriage, birth, adoption or placement for adoption. Coverage for a *special enrollee*, as stated above in Section 3., shall begin on the date the plan adopts the *transitional rule* provision.

   The dependent special enrollment period is a period of thirty (30) days and begins on the date of the marriage, birth, adoption, placement for adoption or notification regarding the *transitional rule.*

F. When Coverage Begins

When the enrollment requirements are met, your coverage begins on the first day of the month coinciding with or next following your date of hire.

Coverage for your eligible dependents begins the later of when your coverage begins or the first day a dependent becomes your dependent.

However, should coverage commence under the Late Enrollment or Special Enrollment Period sections, the provision under these sections will apply.

G. When Coverage Ends

Your coverage ends the earliest of your last day of full-time regular employment; the date you are no longer eligible to participate in the Plan; the date you fail to make the required contributions; or the date the Plan ends.

Coverage for your dependents ends the earliest of the date your coverage ends; the end of the month following the date a dependent no longer meets the eligibility requirements; the date you fail to make the required contributions; or the date the Plan ends.

H. Extension Of Coverage

If you cease to be eligible for coverage due to a temporary layoff, an approved leave of absence, or a *total disability*, you and your eligible dependents may continue to be covered under the Plan. The benefit termination date will be treated the same as an employment termination date with respect to COBRA Continuation of Benefits.

1. Temporary Layoff

   If you are temporarily laid off, eligibility may continue until the date the *employer* ends your continuance, provided you make the required contribution to the Plan.

2. Leave of Absence

   If you qualify for an approved family or medical leave of absence (as defined in the Family and Medical Leave Act of 1993 (FMLA)), eligibility may continue for the duration of the leave. Failure to make payment within thirty (30) days of the due date established by your *employer* will result in the termination of coverage. If you fail to return to work after the leave of absence, your *employer* has the right to recover from you any contributions that were made on your behalf toward the cost of coverage during the leave.

   If you are on any other approved leave of absence, eligibility may continue until the *employer* ends your continuance, provided you make the required contribution to the Plan.

3. Total Disability

If you are covered under the Plan and your active service terminates due to *total disability*, you may continue to be covered under the Plan until the *employer* ends your continuance or until the disability ends, whichever occurs first. Continuation under this section of the Plan may be combined with that period of time determined to be allowable under the Family and Medical Leave Act of 1993.

You may not be engaged in any other occupation for compensation, profit or gain while *totally disabled.* In addition, if you fail to make the required contribution when due, coverage will terminate at the end of the period for which you made the last required contribution.

I. Reinstatement Of Coverage

If you terminate employment for any reason and are rehired, you will be considered a new hire and will be required to satisfy all eligibility and enrollment requirements. However, if you are returning to work directly from COBRA coverage, you will not have to re-satisfy your waiting period.

J. The Uniformed Services Employment And Re-employment Rights Act (USERRA)

This Plan will comply with the requirement of all the terms of The Uniformed Services Employment And Re-employment Rights Act of 1994 (USERRA). This is a federal law which gives members and former members of the U.S. armed forces (active and reserves) the right to return to their civilian job they held before military service.

ARTICLE II -- MEDICAL MANAGEMENT PROGRAM

A. What Is Medical Management

Skidmore College desires to provide you and your family with a health care benefit plan that helps protect you from significant health care expenses and helps to provide you with quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used.

THE PROGRAM IS NOT INTENDED TO DIAGNOSE OR TREAT MEDICAL CONDITIONS, GUARANTEE BENEFITS, OR VALIDATE ELIGIBILITY. The medical professionals who conduct the program focus their review on the appropriateness of *hospital* stays. Any questions pertaining to eligibility, Plan limitations or *fee schedules* should be directed to the eligibility and claims department.

Your participating *physician* or *provider* is required to call to obtain certification prior to:

- Any *inpatient hospital* admission
- *Skilled nursing facility*
- Home health care, except for home infusion therapy
- Outpatient surgery for select procedures
- MRI/MRA/CAT/PET for local providers only
- Select durable medication equipment
- Select injectable medications, non-self administered
- Select orthotics and external prosthetics
- Post mastectomy prosthetics and surgical bras

B. Reduced Benefits For Failure To Follow Required Review Procedures

When the required review procedures outlined above are followed, your benefits will be unaffected. However, failure to comply with this provision may result in a penalty being applied to eligible expenses related to the treatment:

- When services are received from a participating provider, precertification will be obtained by the *health care provider*. If certification is not received, the benefit paid to the provider may be reduced. You cannot be billed for the amount of the benefit reduction.

- If services are not provided by a participating provider, precertification will be your responsibility. Failure to obtain precertification when any of the above services are rendered may result in a reduction of benefits.

ARTICLE III -- NETWORK PROVISIONS

In a PPO Plan, you may see any *health care provider* in or out of the network for covered health care services whenever you like. However, when you see a *health care provider* who is not a participating provider, you will receive a lesser benefit as outlined on the Schedule of Medical Benefits, and your out-of-pocket expenses will be greater.

Referrals by participating providers to non-participating providers will be considered as out-of-network services or supplies and will be payable at the out-of-network benefit level. In order to have services and supplies paid at the in-network benefit level, ask your *physician* to refer you to participating providers (e.g. x-ray specialists, etc.).

Exceptions:

If you receive emergency room treatment at an in-network facility, any services rendered by a physician during the emergency room encounter will be reimbursed at the in-network benefit level, regardless of whether the provider is participating with the contracted network.

Professional Components charges rendered in an in-network facility regardless of whether the provider is participating with the preferred provider organization will be reimbursed at the in-network benefit level.

ARTICLE IV -- MEDICAL BENEFITS

A. About Your Medical Benefits

All medical benefits provided under this Plan must satisfy some basic conditions. The following conditions which apply to your Plan's benefits are commonly included in medical benefit plans but often overlooked or misunderstood.

1. Medical Necessity

   The Plan provides benefits only with respect to covered services and supplies which are *medically necessary* in the specific treatment of a covered *illness* or *injury*, unless specifically mentioned in Covered Medical Expenses. *Medically necessary* means the treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

   "Proven" means the care is not considered *experimental*, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA), if applicable.

   "Effective" means the treatment's beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, *injury, illness* or a clinical condition.

   "Appropriate" means the treatment's timing and setting are proper and cost effective.

   Medical treatments which are not proven, effective and appropriate are not covered by the Skidmore College Employee Benefit Plan unless specifically mentioned.

2. Health Care Providers

   The Plan provides benefits only for covered services and supplies rendered by a *physician, practitioner, nurse, hospital*, or *specialized treatment facility* as those terms are specifically defined in the Definitions section.

3. Custodial Care

   The Plan does not provide benefits for services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider.*

4. Calendar Year

The word *year,* as used in this document, refers to the *calendar year* which is the twelve (12) month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *calendar year.*

5. Alternate Benefit Provision

The *Plan Administrator*, with prior approval from the excess loss carrier, may elect to provide alternative benefits which are not listed as covered services in this contract. The alternative covered benefits should be determined on a case by case basis by the *Plan Administrator* for services which the *Plan Administrator* deems are *medically necessary*, cost effective and agreeable to the covered person and participating provider. The *Plan Administrator* shall not be committed to provide these same, or similar alternative benefits for another covered person nor shall the *Plan Administrator* lose the right to strictly apply the express provisions of this contract in the future.

B. Deductibles

A deductible is the amount of covered expenses you must pay during each *year* before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that *year*. Co-payments and penalties are not applied to the deductible.

If two (2) or more covered members of your family are injured in a common accident, the deductible will be applied only once to all involved persons for those injuries.

C. Coinsurance

Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible. These percentages apply only to covered expenses which do not exceed *fee schedules.* You are responsible for all non-covered expenses and any amount which exceeds the *fee schedule* for out-of-network covered expenses.

The coinsurance percentages are shown on the Schedule of Medical Benefits.

D. Maximum Out-Of-Pocket Amount

A maximum out-of-pocket amount is the maximum amount of covered expenses you must pay during a *year,* including the deductible, before the payment percentage of the Plan increases. The individual maximum out-of-pocket amount applies separately to each covered person. When a covered person reaches their annual maximum out-of-pocket amount, the Plan will pay one hundred percent (100%) of additional covered expenses, subject to any applicable co-payments, for that individual during the remainder of that *year.*

The family maximum out-of-pocket amount applies collectively to all covered persons in the same family. When the family reaches their annual maximum out-of-pocket amount, the Plan will pay one hundred percent (100%) of additional covered expenses, subject to any applicable co-payments, for that family during the remainder of that *year*.

The maximum out-of-pocket amount excludes charges in excess of the *fee schedule*, any co-payments and any penalties for failure to comply with the requirements of the Health Care Management Program.

The annual individual and family maximum out-of-pocket amounts are shown on the Schedule of Medical Benefits.

E. Benefit Maximums

Total Plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as annual or *lifetime.* Whenever the word *lifetime* appears in this Plan in reference to benefit maximums, it refers to the time you or your dependents are covered by this Plan.

The benefit maximums applicable to this Plan are shown in the Schedule of Medical Benefits.

F. Covered Medical Expenses

When all of the requirements of this Plan are satisfied, the Plan will provide benefits as outlined on the Schedule of Medical Benefits but only for the services and supplies listed in this section.

Hospital Services

1. Room and board, not to exceed the cost of a semiprivate room or other accommodations unless the attending *physician* certifies the *medical necessity* of a private room. If a private room is the only accommodation available, the Plan will cover an amount equal to the prevailing semiprivate room rate in the geographic area.

   The Plan may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

   The attending provider, after consulting with the mother, may discharge the mother and newborn earlier than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section.

2. *Intensive care unit* and coronary care unit charges.

3. Miscellaneous *hospital* services and supplies required for treatment during a *hospital* confinement.

4. Well-baby nursery and *physician* expenses during the initial *hospital* confinement of a newborn.

5. *Hospital* confinement expenses for dental services if the attending *physician* certifies that hospitalization is necessary to safeguard the health of the patient.

6. *Outpatient hospital* services.

Emergency Services

1. Treatment in a *hospital* emergency room or other emergency care facility.

2. Ground transportation provided by a professional ambulance service for the first trip to the nearest *hospital* or emergency care facility equipped to treat a condition that can be classified as a *medical emergency*.

Specialized Treatment Facilities

1. A *skilled nursing facility* or *extended care facility*.

2. An *ambulatory surgical facility*.

3. A *birthing center*.

4. A mental/nervous treatment facility.

5. A substance abuse treatment facility.

6. A *hospice facility*.

7. An urgent care center.

Surgical Services

1. Surgeon's expenses for the performance of a surgical procedure.

2. Assistant surgeon's expenses not to exceed twenty percent (20%) of the *fee schedule* of the surgical procedure.

3. Two (2) or more surgical procedures performed during the same session through the same incision, natural body orifice or operative field. The amount eligible for consideration is the *fee schedule* for the largest amount billed for one (1) procedure plus fifty percent (50%) of the sum of *fee schedules* for all other procedures performed.

4. Anesthetic services, when performed by a licensed anesthesiologist or certified registered *nurse* anesthetist in connection with a surgical procedure.

5. *Oral surgery*, limited to the removal of tumors and cysts; incisions of sinuses, salivary glands, or ducts; excision of benign bony growths; external incision and drainage of cellulitis; frenectomy; cleft lip and palate; extracting partial or completely unerupted teeth; and treatment of an accidental *injury* to sound and natural teeth. Treatment of an accidental *injury* must be completed within twelve (12) months of the date of the *injury*.

6. Reconstructive *surgery:*

    a. when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part;

    b. when needed to correct damage caused by an *illness* or accidental *injury;* or

c. breast reconstructive *surgery* in a manner determined in consultation with the attending *physician* and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, *surgery* and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. This Plan is in compliance with the Women's Health and Cancer Rights Act of 1998.

7. Organ and tissue transplant services to an organ transplant recipient who is covered under this Plan. In addition, benefits will be provided for *inpatient hospital* expenses of the donor of an organ for transplant to a covered recipient and for *physician's* expenses for surgical removal of the donor organ if the donor does not have coverage through another group plan. No benefits will be provided for organ selection, transportation and storage costs, or when benefits are available through government funding of any kind, or when the recipient is not covered under this Plan.

8. Circumcision.

9. *Outpatient surgery*.

10. Amniocentesis when the attending *physician* certifies that the procedure is *medically necessary*.

11. Surgical treatment of temporomandibular joint dysfunction (TMJ) and other craniomandibular disorders.

12. Elective sterilization.

13. Elective termination of pregnancy.

Mental/Nervous Conditions and Substance (Drug or Alcohol) Abuse Treatment

1. *Inpatient* mental/nervous and substance abuse treatment.

2. *Outpatient* mental/nervous and substance abuse treatment.

3. Treatment of an eating disorder, following initial visit to a *physician* for diagnosis.

4. Electro-shock therapy.

Medical Services

1. *Physician* office visits relating to a covered *illness* or *injury*.

2. Initial physician examination and subsequent physician office visits for prescription of medication for the treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD).

3. *Inpatient physician* visits by the attending or non-attending *physician*.

4. *Second surgical opinions*.

5. Pregnancy and related maternity care for all covered females.

6. Services to achieve the diagnosis of infertility and subsequent supplies and treatment, including but not limited to, artificial insemination, embryo transplant, sperm processing and in-vitro.

7. Inpatient private duty nursing care provided by a Registered Graduate *Nurse* (R.N.) or a Licensed Practical *Nurse* (L.P.N.) if *medically necessary*.

8. Dental services received after an accidental *injury* to sound and natural teeth including replacement of such teeth; and any related x-rays and dental services must be completed within twelve (12) months of the date of the *injury*.

9. Radiation therapy.

10. Chemotherapy.

11. Hemodialysis.

12. Chiropractic services excluding *maintenance care* and palliative treatment.

13. Podiatric services for treatment of an *illness or injury*, or due to metabolic or peripheral vascular disease.

14. Home health care that is provided by a *home health care agency* (each home health care team member is equal to 1 visit). The following are defined as covered home health care services and supplies upon referral of the attending *physician*:

    a. Part-time nursing services provided by or supervised by a registered *nurse* (R.N.);

    b. part-time or intermittent home health aide services;

c. physical, occupational, speech or respiratory therapy which is provided by a qualified therapist;

d. laboratory services, drugs, medicines, IV therapy and medical supplies which are prescribed by the doctor.

15. *Hospice care* (including bereavement counseling) provided that the covered person has a life expectancy of six (6) months or less and subject to the maximums, if any, as set forth in the Schedule of Benefits. Covered *hospice care*, *respite care* and bereavement expenses are limited to:

    a. room and board for confinement in a *hospice facility*;

    b. ancillary charges furnished by the hospice while the patient is confined therein, including rental of *durable medical equipment* which is used solely for treating an *injury* or *illness*;

    c. nursing care by a registered *nurse*, a licensed practical *nurse*, or a licensed vocational *nurse* (L.V.N.);

    d. home health aide services;

    e. home care charges for home care furnished by a *hospital* or *home health care agency*, under the direction of a hospice, including *custodial care* if it is provided during a regular visit by a registered *nurse*, a licensed practical *nurse*, or a home health aide;

    f. laboratory services, drugs, medicines, IV therapy and medical supplies which are prescribed by the doctor.

    g. medical social services by licensed or trained social workers, psychologists, or counselors;

    h. nutrition services provided by a licensed dietician;

    i. counseling and emotional support services by a licensed social worker or a licensed pastoral counselor; and

    j. bereavement counseling by a licensed social worker or a licensed pastoral counselor for the covered person's immediate family.

16. Physical therapy received from a qualified *practitioner* under the direct supervision of the attending *physician*, excluding *maintenance care* and palliative treatment.

17. Cardiac rehabilitation therapy received from a qualified practitioner under the direct supervision of the attending physician, in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

18. Speech therapy from a qualified *practitioner* to restore normal speech loss due to an *illness*, *injury* or surgical procedure. If the loss of speech is due to a birth defect, any required corrective *surgery* must have been performed prior to the therapy.

19. Occupational therapy but not to include vocational, educational, recreational, art, dance or music therapy.

20. Pulmonary therapy.

21. Respiratory therapy.

22. Initial examination for the treatment of eating disorders (e.g., bulimia, anorexia).

23. Allergy testing and treatment.

24. Preparation of serum and injections for allergies.

25. Sleep studies.

26. Temporomandibular joint dysfunction (TMJ): non-surgical treatment or treatment for prevention of TMJ, craniomandibular disorders, and other conditions of the joint linking the jawbone and skull, muscles, nerves, and other related tissues to that joint.

27. Diabetic education programs.

28. Non-surgical charges for morbid obesity, limited to *medical necessity*.

29. Alternative health programs including memberships for fitness or wellness centers. Individual classes are not considered memberships. Additional alternative health programs include benefits for acupuncture, massage therapy, nutritional counseling, hypnotherapy for smoking cessation or weight control, and homeopathic care. Child birth classes are added effective May 1, 2011. Homeopathy principles are designed to enhance the body's natural protective mechanisms. When the service of Homeopaths are payable by this Plan, the Homeopath must be properly licensed to practice homeopathy in the state in which he or she is practicing and must be performing services within the scope of that license; or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in Homeopathy from an institution which is approved by the American Institute of Homeopathy; or has been certified through the North

American Society of Homeopaths with a Certificate in RSHom (NA) (Registered Society of Homeopathy); or certified through the Council of Homeopathic Certification (CHC) with a certificate in CCH (Certification in Classical Homeopathy); DHANP (Diplomate Homeopathic Association of Naturopathic Physician); and DHt (Diplomate of Homeotherapeutics). Office visits including prescribed homeopathic remedies will be reimbursed under the alternative health care section for Homeopathic. These are the basic guidelines for Alternative Health Programs that are covered within this Plan.

30. Charges related to a provider discount for covered medical expenses resulting in savings to this Plan.

Diagnostic X-Ray and Laboratory Services

1. *Diagnostic charges* for x-rays.

2. *Diagnostic charges* for laboratory services.

3. Preadmission testing (PAT).

4. Ultrasounds, prenatal laboratory and pregnancy testing.

5. Genetic testing.

Equipment and Supplies

1. *Durable medical equipment*, including expenses related to necessary repairs and maintenance. A statement is required from the prescribing *physician* describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased. Initial replacement equipment is covered if the replacement equipment is required due to a change in the patient's physical condition; or, purchase of new equipment is less expensive than repair of existing equipment.

2. Artificial limbs and eyes and replacement of artificial eyes and limbs if required due to a change in the patient's physical condition; or, replacement is less expensive than repair of existing equipment.

3. Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment.

4. Blood and/or plasma, if not replaced, and the equipment for its administration including autologous blood transfusions when performed at the participating facility where related surgery will be performed.

5. Insulin infusion pumps.

6. Replacement of the human lens lost through intraocular *surgery* due to cataract surgery.

7. Sterile surgical supplies after *surgery*.

8. Original fitting, adjustment and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters or traction apparatus, when prescribed by a *physician*, to replace lost body parts or to aid in their function when impaired. Replacement of such devices will be covered only if the replacement is necessary due to a change in the physical condition of the covered person.

9. Orthotics (excluding footwear) and external prosthetics. Effective June 1, 2011, orthotic devices are covered when prescribed by a physician.

10. Jobst garments.

11. Drugs, medicines, or supplies administered through the *physician's* office, for which the patient is charged.

12. Post mastectomy prosthetic and surgical bra.

13. Diabetic equipment and supplies.

14. Medical supplies, including but not limited to, syringes, colostomy supplies and intrauterine devices.

Preventive Care

Preventive care is subject to the limitations and maximums described in the Schedule of Benefits. Preventive care includes the following:

1. Routine physical examination including related laboratory and x-ray testing.

2. Routine well child care examinations including related laboratory and x-ray testing.

3. Routine immunizations.

4. Routine flu vaccination.

5. Routine hearing examination.

6. Routine gynecological examination including Pap test.

7. Routine mammogram.

8. Routine prostate screening.

9. Routine colonoscopy for individuals age 50 and older (effective May 1, 2011).

G. Medical Expenses Not Covered

The Plan will not provide benefits for any of the items listed in this section, regardless of *medical necessity* or recommendation of a *health care provider*. This list is intended to give you a general description of expenses for services and supplies not covered by the Plan. The Plan only covers those expenses for services and supplies specifically described as covered in the preceding section. There may be expenses in addition to those listed below which are not covered by the Plan.

General Exclusions

1. Services, supplies or treatment exceeding the *fee schedule* for the geographic area in which services are rendered.

2. Expenses unnecessary for diagnosis of an *illness* or *injury*, except as specifically mentioned in Covered Medical Expenses.

3. Services, supplies or treatment not prescribed or recommended by a *health care provider*.

4. Services, supplies, or treatment not *medically necessary*.

5. Experimental equipment, services, or supplies which have not been approved by the United States Department of Health and Human Services, the American Medical Association (AMA), or the appropriate government agency.

6. Services, supplies or treatment furnished by or for the United States Government or any other government, unless payment is legally required.

7. Any condition, disability or expense sustained as a result of being engaged in an activity primarily for wage, profit or gain, and for which the covered person benefits are provided under Worker's Compensation Laws or similar legislation.

8. Any condition, disability, or expense sustained as a result of being engaged in: an illegal occupation; commission or attempted commission of an assault or other illegal act; participating in a civil revolution or riot; duty as a member of the armed forces of any state or country; or a war or act of war which is declared or undeclared.

9. Educational, vocational, or training services and supplies, except as specifically mentioned in Covered Medical Expenses.

10. Expenses for telephone conversations, charges for failure to keep a scheduled appointment, or charges for completion of medical reports, itemized bills, or claim forms.

11. Mailing and/or shipping and handling expenses.

12. Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.

13. Medical treatment and travel outside of the United States if the sole purpose of the travel is to obtain medical service, supplies or drugs.

14. Communication, transportation expense, or travel time of *physicians* or *nurses*.

15. Expenses resulting from penalties, exclusions or charges in excess of allowable limits imposed by HMO, non-HMO, or PPO providers resulting from failure to follow the required procedures for obtaining services or treatment.

16. Services, supplies or treatment for which there is no legal obligation to pay, or expenses which would not be made except for the availability of benefits under this Plan.

17. Professional services performed by a person who ordinarily resides in your household or is related to the covered person, such as a *spouse*, parent, child, brother, sister, or in-law.

18. Expenses used to satisfy plan deductibles, co-payments, or applied as penalties.

19. Expenses eligible for consideration under any other plan of the *employer.*

20. Expenses incurred as the result of an auto accident up to the amount of any state required automobile insurance with respect to those expenses.

21. Expenses incurred for services rendered prior to the effective date of coverage under this Plan or expenses for services performed after the date coverage terminates.

Additional Exclusions

The following exclusions are in alphabetical order to assist you in finding information quickly; however, you should review the entire list of exclusions when trying to determine whether a particular treatment or service is covered as the wording of the exclusion may place it in a different location than you might otherwise expect.

1. Adoption expenses.

2. Biofeedback.

3. Breast prosthetic implant removals whether inserted for cosmetic reasons or due to a mastectomy are not covered, unless the removal is *medically necessary*.

4. *Cosmetic* or reconstructive *surgery* unless specifically mentioned in Covered Medical Expenses.

5. Dental services, dental appliances or treatment including hospitalization for dental services, except as specifically mentioned in Covered Medical Expenses.

6. Dispensing fees for drugs, medicines and supplies received in a Physician's office.

7. Donor expenses unless specifically mentioned in Covered Medical Expenses.

8. Drugs, medicine, or supplies that do not require a *physician's* prescription.

9. Education, counseling, or job training for learning disorders or behavioral problems whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment.

10. Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs, and any other clothing or equipment which could be used in the absence of an *illness* or *injury.*

11. Eyeglasses or lenses, orthoptics, vision therapy or supplies.

12. Family counseling.

13. Foot treatment, palliative or cosmetic, including flat foot conditions, orthopedic or corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

14. Genetic counseling.

15. Hearing aids or related supplies.

16. *Hospital* confinement for physiotherapy, hydrotherapy, convalescent care, or rest care.

17. Kerato-refractive eye *surgery* (to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea including, but not limited to, radial keratotomy and keratomileusis *surgery*).

18. Marital counseling.

19. Methadone maintenance.

20. Orthodontics for cleft palate.

21. Outpatient private duty nursing.

22. Personal comfort or service items while confined in a *hospital* including, but not limited to, radio, television, telephone, and guest meals.

23. Prescription drugs or medicines other than specifically mentioned in any Covered Medical Expenses section.

24. Preventive care unless specifically mentioned in Covered Medical Expenses.

25. Reversal of any elective surgical procedure, including voluntary sterilization.

26. Sales tax.

27. Sanitarium, rest, or *custodial care*.

28. Sex change *surgery*.

29. Sex counseling.

30. Smoking cessation programs, care or treatment, unless *medically necessary* due to a severe active lung illness such as emphysema or asthma.

31. Surrogate expenses, including use of a surrogate by a covered individual or services as a surrogate by a covered individual.

32. Vitamins and nutritional supplements, regardless of whether or not a *physician's* prescription is required.

33. Weight reduction or control, including surgery, treatments, instructions, activities, or drugs and diet pills, whether or not prescribed by a *physician*, except as specifically mentioned in Covered Medical Expenses.

34. Wigs and artificial hair pieces.

ARTICLE V -- VISION CARE BENEFITS

A. About Your Vision Benefits

All vision benefits provided under this Plan must satisfy some basic conditions. The following conditions, which apply to your Plan's vision benefits, are commonly included in vision benefit plans but are often overlooked or misunderstood.

1. Participating Vision Care Provider

   A participating vision care provider is a duly licensed optometrist, a duly licensed ophthalmologist, or a duly licensed optician who has a written agreement with the network or a delegated entity to provide you with covered services.

   For maximum vision care benefits, utilize PPO plan participating optometrists and ophthalmologists.

2. Calendar year

   The word *year*, as used in this document, refers to the *calendar year* which is the twelve (12) month period beginning January 1 and ending December 31. All annual benefit maximums accumulate during the *calendar year.*

B. Benefit Maximums

Total Plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific categories or to all benefits. A benefit maximum amount also applies to a specific time period and usually has a frequency limitation.

The benefit maximum amounts and frequency limitations are shown on the Schedule of Vision Care Benefits.

C. Covered Vision Expenses

1. Routine vision examinations by a *physician* or *practitioner* which include case history, visual acuity (clearness of vision), external examination and measurement; interior examination with ophthalmoscope; pupillary reflexes and eye movements; retinoscopy (shadow test); subjective refraction; coordination measure (far and near); medicating agents for diagnostic purposes; and analysis of findings with recommendations and prescription, if required.

2. Prescription lenses.

3. Prescription eyeglass frames.

4. Prescription contact lenses.

5. Scratch resistent coating.

6. Anti-reflective coating.

7. Ultraviolet coating.

8. Photo-chromatic lenses.

9. Tinting.

D. Vision Expenses Not Covered

The Plan will not provide benefits for any of the items listed in this section. This list is intended to give you a general description of expenses for services and supplies not covered by the Plan. This Plan only covers those expenses specifically described as covered in the preceding section. There may be expenses in addition to those listed below that are not covered by the Plan.

1. Services received more frequently than outlined in the Schedule of Vision Care Benefits.

2. Services in excess of the maximum as stated in the Schedule of Vision Care Benefits.

3. Services or supplies for which there is no legal obligation to pay, or expenses that would not be made except for the availability of benefits under this Plan.

4. Services furnished by or for the U.S. Government or any other government unless payment is legally required.

5. Any condition, disability, or expense sustained as a result of being involved in an automobile accident or any incident for which an automobile insurance policy is liable, whether or not any state mandated automobile coverage policy is in effect.

6. Training or educational instruction and materials.

7. Expenses for telephone conversations, charges for failure to keep a scheduled appointment, or charges for completion of medical reports, itemized bills, or claim forms.

8. Mailing and/or shipping and handling expenses.

9. Charges resulting from penalties, exclusions, or charges in excess of allowable limits imposed by HMO, non-HMO or PPO providers resulting from failure to follow the required procedures for obtaining services or treatment.

10. Professional services performed by a person who ordinarily resides in your household or who is related to the covered person such as a spouse, parent, child, brother, sister, or in-law.

11. Experimental equipment, services or supplies that have not been approved by the U.S. Department of Health and Human Services, the American Medical Association (AMA), or the appropriate government agency.

12. Expenses eligible for consideration under any other plan of the *employer*.

13. Services or supplies not prescribed by a *physician* or rendered by a covered *practitioner*.

14. Safety glasses or goggles.

15. Sunglasses, including prescription type.

16. Drugs or medications not used for the purpose of examination or tonometry.

17. Medical and/or surgical treatment of the eye.

18. Special procedures such as, but not limited to, orthoptics, vision training, or subnormal vision aids.

19. Replacement of lost, stolen or broken lenses and/or frames unless within the frequency limitations as specifically mentioned in the Schedule of Vision Care Benefits.

20. Examination, or lenses and/or frames ordered before the covered person was eligible for coverage or expenses for services performed or provided after coverage terminated.

ARTICLE VI -- COORDINATION OF BENEFITS (COB)

A. General Provisions

When you and/or your dependents are covered under more than one (1) group health plan, the combined benefits payable by this Plan and all other group plans will not exceed one hundred percent (100%) of the eligible expense incurred by the individual. The plan assuming primary payor status will determine benefits first without regard to benefits provided under any other group health plan. Any group health plan which does not contain a coordination of benefits provision will be considered primary.

When this Plan is the secondary payor, it will reimburse, subject to all Plan provisions, the balance of remaining expenses, not to exceed normal Plan liability.

B. Automobile Coverage

Benefits payable under this Plan will be coordinated with benefits provided or required by any no-fault automobile coverage statute, whether or not a no-fault policy is in effect, and/or any other automobile coverage. This Plan will be secondary to any state mandated automobile coverage for services and supplies eligible for consideration under this Plan.

C. Federal Programs

The term "group health plan" includes the Federal programs *Medicare* and Medicaid. The regulations governing these programs take precedence over the order of determination of this Plan.

D. Order Of Benefit Determination – Employee / Spouse

When all other group health plans covering you and/or your spouse contain a coordination of benefits provision, order of payment will be as follows:

1. The plan covering a person as an active employee will be primary over a plan covering the same person as a dependent, a retiree, a laid-off individual or in some other capacity.

2. When a person is an active employee under more than one (1) plan, the plan covering the individual for the longer period of time will be considered primary.

3. The plan covering a person as an employee or a dependent will be primary over the plan providing continuation coverage (COBRA).

E. Order Of Benefit Determination – Children

The group health plan covering an individual as a dependent child of non-divorced or non-separated parents will be primary according to which parent has the earlier birth date (month and day) in the year. If both parents have the same birth date, the plan covering the child for the longer period of time will be primary.

When all plans covering a person as a dependent child of divorced or separated parents contain a coordination of benefits provision, the order of payment will be:

1. The plan covering the dependent child of the natural parent designated by court order to be responsible for the child's health care expenses will be considered primary.

2. In the absence of a court order specifying otherwise, the plan covering the dependent child of the natural parent having legal custody of the child will be considered primary.

3. In the absence of a court order specifying otherwise, the plan covering the dependent child of a stepparent who is the spouse of the natural parent having legal custody of the child will be considered primary.

4. If there is a court decree stating that both parents share joint custody, without stipulating that one of the parents is responsible for the child's health care expenses, the Birthday Rule will be used to determine the order in which benefits are considered.

F. Order Of Benefit Determination - Medicare

If you are entitled to *Medicare* for any reason but chose not to enroll under *Medicare* Parts A and B when entitled, this Plan will process your claims as though *Medicare* Parts A and B had been elected. If the Plan determines that *Medicare* would have been the primary payor, if enrolled, this plan will calculate the amount that Traditional *Medicare* Parts A and B would have paid and coordinate benefits accordingly.

Many factors determine whether this Plan or *Medicare* is the secondary payor for you and your spouse including the number of people employed by your *employer* and disabling *illness* for which an individual is treated. This plan does not discriminate against *Medicare* beneficiaries for whom *Medicare* is the secondary payer. This Plan will not coordinate benefits for prescription drugs for an individual enrolled in a *Medicare* D plan. If you or your dependent enrolls in a *Medicare* D plan, benefits available under this Prescription Drug Plan will be terminated – such termination may result in termination of all Plan coverage.

If you are entitled to *Medicare* and remain actively at work (for an employer which employs more than 20 employees) you or your spouse may choose to remain covered under this Plan without reduction in *Medicare* benefits or you may designate *Medicare* as the exclusive payor of benefits. If you choose *Medicare* as the exclusive payor of benefits, coverage under this Plan will end. If you do not specifically choose *Medicare* as the exclusive payor of benefits, this Plan will continue to be primary. .If you are under age sixty-five (65) and your spouse is over age sixty-five (65), he or she can make their own choice.

G. Right To Make Payments To Other Organizations

Whenever payments which should have been made by this Plan have been made by any other plan(s), this Plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision.

Amounts paid will be considered benefits paid under this Plan and, to the extent of such payments, the Plan will be fully released from any liability regarding the person for whom payment was made.

ARTICLE VII -- SUBROGATION

This Plan will be reimbursed 100% of any amounts paid whenever another party or parties is legally responsible or agrees to pay money due to an *illness* or *injury* suffered by you or your dependent(s).

Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan, without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, provisions of state law or otherwise.

Acceptance of benefits under this Plan is constructive notice of this provision in its entirety and that you, your covered dependent, your representative, your covered dependent's representative or anyone else agrees:

1. That you will notify the Plan Administrator of any settlement with such third party and notify the Plan Administrator of any lawsuit filed by you or on your behalf against such third party.

2. To fully cooperate with the terms and conditions of this Plan. If you or your covered dependent choose not to act to recover money from any source, the Plan Administrator reserves the right to initiate its own direct action to obtain reimbursement.

3. That the benefits paid or to be paid by this Plan will be secondary, not primary.

4. That reimbursement to this plan will be 100% of amounts paid without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, provisions of state law or otherwise.

5. That reimbursement to this plan will be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency.

6. That you or any attorney that is retained by you will not assert the Common Fund or Made-Whole Doctrine;

7. That any amount recovered by a dependent minor or on behalf of a dependent minor by a trustee, guardian, parent or other representative of the minor shall be reimbursed to the Plan regardless of whether the minor's representative has access or control of any recovery funds.

8. To sign any documents requested by the Plan Administrator, or any representative of the Plan Administrator including but not limited to reimbursement and/or subrogation agreements. In addition, you agree to furnish any other information that might be requested by the Plan Administrator or representative of the Plan Administrator. Failure or refusal to execute such agreements or furnish information does not preclude the Plan Administrator or any representative of the Plan Administrator from exercising its right to subrogation or obtaining full reimbursement.

9. To take no action which will, in any way, prejudice the rights of the Plan. (If it becomes necessary for the Plan Administrator or any representative of the Plan Administrator to enforce this provision by initiating any action against you, your covered dependent, your representative, your covered dependent's representative or anyone else, you will be responsible to pay the fees of the Plan Administrator's attorney and all costs associated with the action regardless of the outcome of the action.)

Any claims related to the accident or *illness* made after satisfaction of this obligation shall be the responsibility of the covered person, not the Plan.

ARTICLE VIII -- OTHER IMPORTANT PLAN PROVISIONS

A. Special Election For Employees Age Sixty-Five (65) And Over

If you remain actively at work after reaching age sixty-five (65), you or your *spouse* may choose to remain covered under this Plan without reduction in *Medicare* benefits or designate *Medicare* as the exclusive payor of benefits. **If you choose to remain covered under this Plan, this Plan will be the primary payor of benefits and *Medicare* will be secondary**. If you choose *Medicare* as primary, coverage under this Plan will end. If you do not specifically choose one of the options, this Plan will continue to be primary.

If you are under age sixty-five (65) and your *spouse* is over age sixty-five (65), he or she can make their own choice.

B. Medicaid-Eligible Employees And Dependents

If you or your dependents are Medicaid-eligible, you will be entitled to the same coverage under the Plan as all other employees and dependents. The benefits of this Plan will be primary to those payable through Medicaid.

C. Recovery Of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these excess payments from any individual (including yourself), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the Plan has the right to withhold payment on your future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

D. Right To Receive And Release Necessary Information

The Plan may, without the consent of or notice to any person, release to or obtain from any organization or person information needed to implement Plan provisions. When you request benefits, you must furnish all the information required to implement Plan provisions.

E. Severability

The provisions of this Plan will be considered severable; therefore, if a provision is deemed invalid or unenforceable, that decision will not affect the validity and enforceability of the other provisions of the Plan.

F. Blue Card Pricing Disclosure

When you obtain health care services from a participating provider outside the geographic area BlueShield of Northeastern New York serves, the amount you pay for covered services is calculated on either:

- The billed charges for your covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price considered by the Host Blue. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, any other contingent payments arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices, however, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Participant liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Participant liability calculation methods that differ from the usual Blue Card method noted above in paragraph one of this Exhibit or require a surcharge, BlueShield of Northeastern New York would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

You will be entitled to benefits for health care services received by you either inside or outside the geographic area BlueShield of Northeastern New York serves, if this plan covers those health care services. Due to variations in Host Blue medical practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area BlueCross BlueShield serves, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area BlueShield of Northeastern New York serves. But in no event will you be entitled to benefits for health care services, whenever you receive them, which are specifically excluded or limited from coverage by this plan.

ARTICLE IX -- CLAIM SUBMISSION PROCESS

A. What Is A Claim Of Benefits

A Claim of Benefits is a request for Plan benefits made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedures for determining benefits. Although additional information is often needed to determine benefits, a Claim of Benefits must include:

Employee Information: Name, Address, Date of Birth, Employer Name, Group Number

Patient Information: Patient Name, Address, Date of Birth, Relationship to Employee, Patient Employment or Student Enrollment, Other Coverage, and Child Custody / Child Support / Adoption.

Treatment Information: Diagnosis, Date(s), Service(s), Treatment Location, Charge(s).

Health Care Provider Information: Name, Address, Telephone Number, Degree, Federal Tax Identification Number.

Additional Information: If additional information exists that may assist in the claim determination, such information should be submitted with the initial request for benefit. Examples of such information are: Operative Report, Pre-operative Photographs, X-ray or Laboratory Report, Description of Accident, Police Report.

When treatment is received from a participating *Health Care Provider*, the claim will be submitted on your behalf. In accordance with the network's agreement with the Participating *Health Care Provider*, your claim must be submitted within ninety (90) days. All other claims must be filed with the Plan within the twelve (12) month period from the date of the expense.

If you have any questions regarding your claim of benefits, please call:

BlueShield of Northeastern New York
Customer Service Department
1- 888-840-6322

B. Filing A Claim Of Benefits

If a Claim of Benefits is submitted that does not conform to Plan procedures, the Plan will furnish you with written notice of any technical deficiency in the claim and the steps necessary to resolve the deficiency within five (5) calendar days of the discovery of the defect in the filing, or in the case of a claim involving urgent care or concurrent care, within twenty-four (24) hours.

All claims must be filed with the Plan within the eighteen (18) month period from the date of the expense.

The following information should be submitted in order to properly file a Claim of Benefits:

Claim Form

Complete the employee portion of the claim form in full. Answer all questions, even if the answer is "None" or “Not Applicable” (N/A), including the section referring to other coverage (Coordination of Benefits “COB”). A separate claim form should be completed for each person for whom benefits are being requested. A claim form may be requested no more than annually for you and each dependent enrolled in this Plan. Mail completed claim forms to the *Claims Administrator.*

Claim of Benefits

You may attach the itemized claim of benefits to the claim form. A claim for benefits may be submitted by you or on your behalf by a *Health Care Provider*.

Primary Carrier Explanation of Benefits

If another plan is the primary payor, a copy of the primary plan's Explanation of Benefits “EOB” must accompany each claim.

Additional Information

If additional information exists that may assist in the claim determination, such information should be submitted with the initial request for benefit. Examples of such information are:

1. Operative Report
2. Pre-operative Photographs
3. X-ray or Laboratory Report
4. Description of Accident
5. Police Report

C. Adverse Benefit Determination

If a claim is wholly or partially denied, the *Plan Administrator* shall furnish you with a written explanation of the Adverse Benefit Determination within a reasonable period of time, but not

later than thirty (30) days after the claim is filed. This thirty (30) day period may be extended once by the *Plan Administrator* for up to fifteen (15) days provided:

1. The *Plan Administrator* determines that an extension is necessary due to circumstances beyond the Plan's control; and

2. The *Plan Administrator* notifies the claimant before the end of the initial thirty (30) day period of the circumstances requiring the extension of time and the date by which the plan intends to render a decision on the claim.

A written explanation of a claim denial will include the following information:

1. The specific reason(s) for the denial of the claim;

2. Reference to the Plan provision(s) on which the denial is based;

3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

4. A description of the plan's appeal procedure and applicable time limits to such procedures;

5. A statement that you, your attorney, or other duly authorized representative shall have, as part of the review procedure, a reasonable opportunity to examine pertinent Plan documents and records, and submit written comments on the issue(s); and

6. A statement regarding the Participant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on appeal.

D. How To Appeal An Adverse Benefit Determination

The denial of a claim shall receive a full and fair review by the *Plan Administrator* upon written request. Such request must be received within one hundred and eighty (180) days after your receipt of the written explanation of the Adverse Benefit Determination. Otherwise, the initial decision of the *Plan Administrator* shall be the final decision of the Plan.

As part of the review procedure, you or your duly authorized representative shall have a reasonable opportunity to examine the Plan document and all other documents, records and other information relevant to the benefit claim, and to submit written comments on the issues.

The *Plan Administrator* shall review the additional information and comments submitted by you or your duly authorized representative. The *Plan Administrator* may hold a hearing of all parties involved, if the *Plan Administrator* deems such hearing to be necessary. The *Plan Administrator* shall furnish you with a written claim appeal determination within a reasonable period of time, but not later than sixty (60) days after the appeal is filed.

A written explanation of a claim appeal determination will include the following information:

1. The specific reason or reasons for the decision, including a response to any information and comments submitted by you or your duly authorized representative;

2. Reference to Plan provisions and records on which the decision is based;

3. A statement that you and your duly authorized representative are entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim; and

4. A statement regarding the Participant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on appeal.

E. Limitations

1. The timeframes for review of Adverse Benefit Determinations will be tolled (i.e., suspended) from the date on which notice was sent to the claimant until the date that the claimant responds to the request for information.

2. No action at law or in equity can be brought to recover under this Plan prior to the expiration of the first one hundred and eighty (180) days after the claim has been filed with the *Plan Administrator*.

3. No action at law or in equity can be brought to recover under this Plan after the expiration of two years after the claim has been filed with the *Plan Administrator*.

All requests for a review of denied benefits should include a copy of the initial denial letter and any other pertinent information. Send all information to BlueShield of Northeastern New York at the claims address indicated on your identification card.

ARTICLE X -- FAMILY AND MEDICAL LEAVE ACT OF 1993

A. Coverage

If you are covered under the Plan and are eligible for an unpaid family or medical leave of absence as provided under the Family and Medical Leave Act of 1993 (FMLA), your coverage may continue during such leave. The FMLA requires any employer with fifty (50) or more employees, as defined by the Act, to maintain health coverage for an employee during a period of eligible leave at the same level and under the same conditions coverage would have been provided if the employee had remained a member of the eligible group and covered under the Plan. You are considered eligible for FMLA leave if you have been employed by the *employer* for at least twelve (12) months, and have performed at least 1,250 hours of service with the *employer* in the twelve (12) months immediately preceding the start of the leave.

B. Reasons For FMLA Leave

You may continue to be covered under the Plan during an approved FMLA leave for one or more of the following reasons:

1. The birth of a son or daughter, in order to care for that son or daughter.

2. The placement of a son or daughter with you for adoption or foster care.

3. In order to care for your spouse, son, daughter, or parent who has a serious health condition unrelated to service in the line-of-duty in the Armed Forces of the United States.

4. Because of a serious health condition that makes you unable to perform the functions of your position.

5. In order to care for a member of the United States Armed Forces, including a member of the National Guard or Reserves. Military caregiver leave may be approved if it meets the following criteria:

    a. You are the spouse or the next-of-kin (the nearest blood relative of that individual) of a member of the Armed Forces who suffered a serious illness or injury in the line-of-duty while on active duty, and

    b. The Armed Forces member is undergoing medical treatment, recuperation, or therapy; is otherwise in outpatient status; or is otherwise on the temporary disability retired list and is medically unfit to perform the duties of the member’s office, grade, rank, or rating.

6. A *qualifying exigency* due to your spouse, son, daughter, or parent's active duty status, or notification of an impending call to active duty status, in support of a contingency operation.

C. Serious Health Condition

For the purposes of Subsections 3. and 4., a serious health condition is defined as an *illness*, *injury*, impairment, or physical or mental condition that involves any period of incapacity or treatment as an *inpatient* in a *hospital*, hospice, or residential medical care facility; any period of incapacity requiring absence from work, school, or other regular daily activities of more than three (3) calendar days that also involves continuing treatment by or under the supervision of a *health care provider*; or continuing treatment by or under the supervision of a *health care provider* for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three (3) calendar days; and for prenatal care. A *health care provider* means a doctor of medicine or osteopathy who is authorized to practice medicine or *surgery* (as appropriate) by the state in which the doctor practices or others capable of providing health care services as defined by the Act.

D. Amount Of Leave

When an FMLA leave is taken in order to care for your spouse, son, daughter, or parent who has sustained a serious line-of-duty related health condition during service in the United States Armed Forces you may continue to be covered for up to twenty-six (26) weeks in a single twelve (12) consecutive month period. Any other approved FMLA leave is limited to twelve (12) weeks in any twelve (12) consecutive month period.

If you and your spouse are both employed by the *employer* the aggregate amount of FMLA leave may not exceed the maximum period described above in any twelve (12) consecutive months if such leave is taken for the birth of a son or daughter, the placement of a son or daughter with you for adoption or foster care, or in order to care for a parent who has a serious health condition. Your entitlement to leave for a birth or placement for adoption or foster care concludes at the end of the twelve (12) month period beginning on the date of the birth or placement.

E. Reduced Leave Schedule

Reduced leave schedule means a leave schedule that reduces the usual number of hours per week, or per day, that you are employed. Approved leave taken for reasons stated in Subsections 1. and 2. above cannot be taken intermittently or on a reduced leave schedule unless the *employer* and you agree otherwise. Approved leave described in Subsections 3. through 6. may be taken intermittently or on a reduced leave schedule when *medically necessary*.

F. Documentation And Procedures

The *employer* may require that leave taken for reasons stated in Subsections 3., 4., and 5 be supported by a certification letter issued by the treating *health care provider*, as appropriate. Military caregiver leave may require supporting certification from, or on behalf of the United States Department of Defense. If the validity of the certification is doubted, the *employer* can request that you obtain a second opinion, at the *employer's* expense, from a *health care provider* designated by the *employer*. If both certification letters are in conflict, the *employer* can request that you obtain, at the *employer's* expense, a third opinion from a provider jointly approved by you and the *employer*. The opinion of the third provider is binding.

You must notify the *employer* of your intention to take a FMLA leave at least thirty (30) days prior to the date the leave is to begin unless you prove that the need for the leave was not reasonably foreseeable. The *employer* may require you to substitute any existing paid leave, such as vacation leave, personal leave, or family leave, for any part of the unpaid FMLA leave.

Coverage will be continued during a FMLA leave at the same level and under the same conditions that coverage would have been provided if you had remained a member of the eligible group and covered under the Plan. Such continuation may be combined with any time allowed under the Extension of Coverage section of the Plan for coverage continuation in the event of a leave of absence or disability. If the *employer* provides a new health care plan of benefits, or changes health benefits or plans while you are on leave, you are entitled to the new or changed plan or benefits to the same extent as if you were not on leave. You will not be subject to the *waiting period* or the *pre-existing condition* limitation, if applicable, when restored to active service with the *employer* regardless of whether or not you chose to retain health coverage during FMLA leave. The *employer* reserves the right to deny restoration to certain Highly Compensated or Key Employees as determined by the conditions defined in the Act.

You must continue to make any required contribution to the Plan in order for coverage to continue. The *employer's* obligation to maintain health coverage under FMLA leave will cease if your contribution is more than thirty (30) days overdue. Failure to make the required contribution to the Plan will terminate coverage at the end of the period for which you made the last required contribution.

Further, failure to return from FMLA leave for reasons other than the continuation, recurrence, or onset of a serious health condition that entitles you to leave under FMLA, or other circumstances beyond your control, may result in the recovery, by the *employer*, of any contributions made by the *employer* toward the continuation of your coverage. When you fail to return from FMLA leave because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the *employer* from recovering any contribution made toward continuation of coverage, the *employer* may require a certification letter issued by your *health care provider* or the *health care provider* of your son, daughter, spouse or parent, as appropriate, verifying the *medical necessity* for continued leave. The certification letter must be submitted within thirty (30) days of the *employer's* request.

The amount that the *employer* may recover is limited to only the *employer's* share of allowable contributions as would be calculated under COBRA Continuation of Benefits excluding the two (2) percent fee for administrative costs. The *employer* may not recover any contributions for any period of FMLA leave covered by paid leave. The employee who returns to active service for at least thirty (30) calendar days is considered to have "returned to work."

The above is in compliance with the Family and Medical Leave Act of 1993, as amended, and the same as may be further amended from time to time.

ARTICLE XI -- COBRA CONTINUATION OF BENEFITS
(Consolidated Omnibus Budget Reconciliation Act)

A. Definitions

For purposes of this Continuation Coverage Under COBRA provision, the following definitions apply:

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

2. "Code" means the Internal Revenue Code of 1986, as amended.

3. "Continuation Coverage" means the Group Health Plan coverage elected by a Qualified Beneficiary under COBRA.

4. "Covered Employee" has the same meaning as that term is defined in COBRA and the regulations thereunder.

5. "Group Health Plan" has the same meaning as that term is defined in COBRA and the regulations thereunder.

6. "Qualified Beneficiary" means:

    a. A Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him ineligible for coverage under the Plan;

    b. A covered spouse or dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below; or

    c. A newborn or newly adopted child of a Covered Employee who is continuing coverage under COBRA.

7. "Qualifying Event" means the following events which, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

    a. Termination of a Covered Employee's employment (other than for gross misconduct) or reduction in his hours of employment;

    b. The death of the Covered Employee;

c. The divorce or legal separation of the Covered Employee from his spouse;

d. A child ceasing to be eligible as a dependent child under the terms of the Group Health Plan; or

e. Your *employer* filing a Chapter 11 bankruptcy petition. Coverage may continue for covered retirees and/or their dependents if coverage ends or is substantially reduced within one year before or after the initial filing for bankruptcy.

8. "Totally Disabled" or "Total Disability" means Totally Disabled as determined under Title II or Title XVI of the Social Security Act.

B. Right To Elect Continuation Coverage

If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Company. A Qualified Beneficiary must elect the coverage within the 60-day period beginning on the later of:

1. The date of the Qualifying Event; or

2. The date he was notified of his right to continue coverage.

If you are considered an eligible worker, in accordance with the Trade Adjustment Assistance Reform Act of 2002 (TAA), you may be entitled to elect COBRA Continuation Coverage during the 60-day period beginning on the first day of the month in which you begin receiving Trade Adjustment Assistance provided that the election is made within the six (6) month period immediately following the date of the TAA-related loss of coverage.

C. Notification Of Qualifying Event

If the Qualifying Event is divorce, legal separation or a dependent child's ineligibility under a Group Health Plan, the Qualified Beneficiary must notify the Company of the Qualifying Event within sixty (60) days of the event in order for coverage to continue. You must report the Qualifying Event to the Plan Administrator in writing. The statement must include:

1. Your name;

2. Your identification number;

3. The dependent's name;

4. The dependent's last known address;

5. The date of the Qualifying Event; and

6. A description of the event.

In the case of a request for extension of the COBRA period as a result of a finding of disability by the Social Security Administration, you must also submit the disability determination. In addition, a Totally Disabled Qualified Beneficiary must notify the Company in accordance with the section below entitled "Total Disability" in order for coverage to continue.

Failure to provide such notice(s) will result in a loss of COBRA entitlement hereunder.

D. Length Of Continuation Coverage

1. A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Group Health Plan for up to eighteen (18) months from the date of the Qualifying Event.

2. A Qualified Beneficiary who loses coverage due to the Covered employee's death, divorce, or legal separation, and dependent children who have become ineligible for coverage may continue coverage under the Group Health Plan for up to thirty-six (36) months from the date of the Qualifying Event.

E. Total Disability

1. In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been Totally Disabled within sixty (60) days of a Qualifying Event (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for dependents who were covered under the Continuation Coverage) for a total of twenty-nine (29) months as long as the Qualified Beneficiary notifies the *employer*:

    a. Prior to the end of eighteen (18) months of Continuation Coverage that he was disabled as of the date of the Qualifying Event; and

    b. Within sixty (60) days of the determination of Total Disability under the Act.

2. The *employer* will charge the Qualified Beneficiary an increased premium for Continuation Coverage extended beyond eighteen (18) months pursuant to this section.

3. If during the period of extended coverage for Total Disability (Continuation Coverage months 19-29) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:

   a. The Qualified Beneficiary shall notify the *employer* of this determination within thirty (30) days; and

   b. Continuation Coverage shall terminate the last day of the month following thirty (30) days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

F. Coordination Of Benefits

Benefits will be coordinated with any federal program, automobile coverage or group health plan in accordance with the provisions described in the Article entitled - Coordination of Benefits.

G. Termination Of Continuation Coverage

Continuation Coverage will automatically end earlier than the applicable 18-, 29-, or 36-month period for a Qualified Beneficiary if:

1. The required monthly contribution for coverage is not received by the Company within thirty (30) days following the date it is due;

2. The Qualified Beneficiary becomes covered under any other Group Health Plan as an employee or otherwise. If the other Group Health Plan contains an exclusion or limitation relating to a *pre-existing condition* (other than a *pre-existing condition* exclusion or limitation which the Qualified Beneficiary satisfies under the Health Insurance Portability and Accountability Act of 1996), and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for Continuation Coverage as long as the exclusion or limitation relating to the *pre-existing condition* applies to the Qualified Beneficiary (or, if sooner, until the expiration of the applicable 18-, 29- or 36-month COBRA period).

3. For Totally Disabled Qualified Beneficiaries continuing coverage for up to twenty-nine (29) months, the last day of the month coincident with or following thirty (30) days from the date of a final determination by the Social Security Administration that such beneficiary is no longer Totally Disabled;

4. The Qualified Beneficiary becomes entitled to *Medicare* benefits; or

5. The Company ceases to offer any Group Health Plans.

H. Multiple Qualifying Events

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is eighteen (18) or twenty-nine (29) months, and a second Qualifying Event occurs during the 18- or 29- month period, the Qualified Beneficiary may elect, in accordance with the section entitled "Right To Elect Continuation Coverage", to continue coverage under the Group Health Plan for up to thirty-six (36) months from the date of the first Qualifying Event.

I. Continuation Coverage

The Continuation Coverage elected by a Qualified Beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Group Health Plan offered to similarly situated Covered Employees and their dependents. The Continuation Coverage is also subject to the rules and regulations under COBRA. If COBRA permits Qualified Beneficiaries to add dependents for Continuation Coverage, such dependents must meet the definition of dependent under the Group Health Plan.

J. Carryover Of Deductibles And Plan Maximums

If Continuation Coverage under the Group Health Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable deductible and co-payment features for the year will be carried forward into the Continuation Coverage elected for that year.

Similarly, amounts applied toward any maximum payments under the Plan will be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

K. Payment Of Premium

1. The Group Health Plan will determine the amount of premium to be charged for Continuation Coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

a. The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102 percent of the applicable premium for that period.

   The American Recovery Reinvestment Act of 2009 (ARRA) temporarily provides federally subsidized COBRA premium assistance in the amount of 65%. This provision applies to those who were involuntarily terminated during the period as defined by ARRA.

b. For Qualified Beneficiaries whose coverage is continued pursuant to the section entitled "Total Disability" of this provision, the Group Health Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed 150 percent of the applicable premium for Continuation Coverage months 19-29.

c. Contributions for coverage may, at the election of the Qualified Beneficiary, be paid in monthly installments.

2. If Continuation Coverage is elected, the monthly contribution for coverage for those months up to and including the month in which election is made must be made within forty-five (45) days of the date of election.

3. Without further notice from the Company, the Qualified Beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Company within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with the section entitled "Termination of Continuation Coverage", Subsection A. This 30-day grace period does not apply to the first contribution required under Subsection B.

4. No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

ARTICLE XII -- PROTECTED HEALTH INFORMATION

This Employee Benefit Plan collects and maintains a great deal of personal health information about you and your enrolled dependents. Federal HIPAA regulations on privacy and confidentiality limit how an Employee Health Plan and its *Plan Administrator* may use and disclose this information. This Article describes provisions that protect the privacy and confidentiality of your personal health information and complies with applicable federal law.

A. Definitions

For purposes of this Article, the following terms shall have the meaning set forth below unless otherwise provided by the Plan:

1. "Electronic Protected Health Information" means Protected Health Information that is transmitted or maintained in any electronic media.

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

3. "Member" means a covered employee or the covered dependents of a covered employee.

4. "*Plan Sponsor*" is Skidmore College.

5. "Plan" is Skidmore College Employee Benefit Plan.

6. "Plan Documents" means the group health plan's governing documents and instruments (i.e., the documents under which the group health plan was established and is maintained), including but not limited to the Skidmore College Plan Document.

7. "Protected Health Information" means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify a member. Protected Health Information includes information of persons living or deceased. The following components of a member's information also are considered Protected Health Information:

    a. Names;

    b. Street address, city, county, precinct, zip code;

    c. Dates directly related to a member, including birth date, health facility admission and discharge date, and date of death;

d. Telephone numbers, fax numbers, and electronic mail addresses;

e. Social Security numbers;

f. Medical record numbers;

g. Health plan beneficiary numbers;

h. Account numbers;

i. Certificate/license numbers;

j. Vehicle identifiers and serial numbers, including license plate numbers;

k. Device identifiers and serial numbers;

l. Web universal resource locators (URLs);

m. Biometric identifiers, including finger and voice prints;

n. Full face photographic images and any comparable images; and

o. Any other unique identifying number, characteristic, or code.

8. "Regulation" means the Health Insurance Portability and Accountability Act of 1996, as amended.

9. "Security Incidents" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system. The Plan Sponsor will report a successful Security Incident to the Plan within a reasonable period of time after learning of the successful security incident. Data relating to an unsuccessful attempt may be aggregated and reported to the Plan on a less frequent basis.

10. "Summary Health Information" means information that may be individually identifiable health information, and

    a. That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and

    b. From which the information described in the regulation has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

B. Permitted And Required Uses And Disclosure Of Protected Health Information

Subject to obtaining written certification, this Plan may disclose Protected Health Information to the *Plan Sponsor*, provided the *Plan Sponsor* does not use or disclose such Protected Health Information except for the following purposes:

1. Performing Plan administrative functions which the *Plan Sponsor* performs for the Plan.

2. Obtaining bids for providing employee coverage under this Plan; or

3. Modifying, amending, or terminating the Plan.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the *Plan Sponsor* be permitted to use or disclose Protected Health Information in a manner that is inconsistent with the regulation.

C. Conditions Of Disclosure

The Plan, or any employee coverage with respect to the Plan, shall not disclose Protected Health Information to the *Plan Sponsor* unless the *Plan Sponsor* agrees to:

1. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.

2. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to Protected Health Information.

3. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or benefit plan of the *Plan Sponsor*.

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

5. Make available to a Plan participant who requests access the Plan participant's Protected Health Information in accordance with the Regulation.

6. Make available to a Plan participant who requests an amendment to the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with the Regulation.

7. Make available to a Plan participant who requests an accounting of disclosures of the participant's Protected Health Information the information required to provide an accounting of disclosures in accordance with the Regulation.

8. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Regulation.

9. If feasible, return or destroy all Protected Health Information received from the Plan that the *Plan Sponsor* still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.

10. Ensure that the adequate separation between the Plan and the *Plan Sponsor* required in the Regulation is satisfied.

D. Certification Of Plan Sponsor

The Plan shall disclose Protected Health Information to the *Plan Sponsor* only upon the receipt of a certification by the *Plan Sponsor* that the Plan has been amended to incorporate the provisions of the Regulation, and that the *Plan Sponsor* agrees to the conditions of disclosure set forth in item C. above.

E. Permitted Uses And Disclosure Of Summary Health Information

The Plan may disclose Summary Health Information to the *Plan Sponsor*, provided such Summary Health Information is only used by the *Plan Sponsor* for the purpose of:

1. Obtaining bids for providing employee coverage under this Plan; or

2. Modifying, amending, or terminating the Plan.

F. Permitted Uses And Disclosure Of Enrollment And Disenrollment Information

The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the *Plan Sponsor*, provided such enrollment and disenrollment information is only used by the *Plan Sponsor* for the purpose of performing administrative functions that the *Plan Sponsor* performs for the Plan.

G. Adequate Separation Between The Plan And The Plan Sponsor

The *Plan Sponsor* shall limit access to Protected Health Information to only those employees authorized by the *Plan Sponsor*. Such employees shall only have access to and use such Protected Health Information to the extent necessary to perform the administration functions that the *Plan Sponsor* performs for the Plan. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the *Plan Sponsor* for non-compliance pursuant to the *Plan Sponsor's* employee discipline and termination procedures.

H. Security Standards For Electronic Protected Health Information

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

2. Plan Sponsor shall ensure that the adequate separation that is required by the Regulation is supported by reasonable and appropriate security measures;

3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

4. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

    a. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

    b. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan's request.

This Plan will comply with the requirement of 45 C.F.R. / 164.314 (b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164.

ARTICLE XIII -- DEFINITIONS

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under Covered Medical Expenses.

Ambulatory Surgical Facility

A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *physicians*; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; and supply registered professional nursing services whenever a patient is in the facility.

Birthing Center

A public or private facility, other than private offices or clinics of *physicians*, which meets the free standing *birthing center* requirements of the State Department of Health in the state where the covered person receives the services.

The *birthing center* must provide: A facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one (1) specialist in obstetrics and gynecology; a *physician* or certified nurse midwife at all births and immediate post partum period; extended staff privileges to *physicians* who practice obstetrics and gynecology in an area *hospital*; at least two (2) beds or two (2) birthing rooms; full-time nursing services directed by an R.N. or certified *nurse* midwife; arrangements for diagnostic x-ray and lab services; the capacity to administer local anesthetic or to perform minor *surgery*.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a *hospital* for emergency transfers, and maintain medical records on each patient and child.

Calendar year

The twelve (12) month period beginning January 1 and ending December 31.

Claims Administrator

BlueShield of Northeastern New York.

Cosmetic Surgery

A procedure performed primarily to improve appearance which does not meaningfully promote the proper function of the body or prevent or treat an *illness, injury* or disease.

Creditable Coverage

Coverages required to be included as such under Section 701(c) of ERISA, and shall exclude those coverages that are permitted to be excluded under Section 701(c) of ERISA. Solely for purposes of illustration and not in limitation of the foregoing, *creditable coverage* generally includes periods of coverage under an individual or group health plan (including *Medicare*, Medicaid, governmental and church plans) that are not followed by a *significant break in coverage* and excludes coverage for liability, limited scope dental or vision benefits, specified disease and/or other supplemental-type benefits. **Days in a *waiting period* are not *creditable coverage***.

Custodial Care

Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

Dental Care Provider

A *dentist, dental hygienist, physician*, or *nurse* as those terms are specifically defined in this section.

Dental Hygienist

A person trained and licensed to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed *dentist*.

Dentist

A person acting within the scope of his/her license, holding the degree of Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), or Doctor of Dental Medicine (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered.

Diagnostic Charges

The *fee schedules* for x-ray or laboratory examinations made or ordered by a *physician* in order to detect a medical condition.

Durable Medical Equipment

Equipment able to withstand repeated use for the therapeutic treatment of an active *illness* or *injury*. Such equipment will not be covered under the Plan if it could be useful to a person in the absence of an *illness* or *injury* and could be purchased without a *physician's* prescription.

Employer

Skidmore College.

Enrollment Date

The first day of coverage or, if there is a *waiting period*, the first day of the *waiting period*.

Experimental/Investigational

Expenses for treatments, procedures, devices or drugs which the *Plan Administrator* determines, in the exercise of its discretion, are *experimental, investigational* or done primarily for research. Such treatments, procedures, devices or drugs are excluded under this Plan unless:

Approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and, reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnoses; and

Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnoses.

Reliable evidence includes anything determined to be such by the *Plan Administrator*, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authorized by the national medical professional community.

Fee Schedule

The *Fee Schedule* is the calculation of the maximum amount payable toward any claim of benefits. The *Fee Schedule* is the negotiated price for local participating providers and a participating provider outside the geographic area that the network serves. The Fee Schedule reflects the maximum amount payable toward a covered expense, participating providers can only bill you for the difference between the benefit paid and the Fee Schedule for any service. Allowed expense for non-participating providers is based on the Usual and Customary charge in the geographic area where the services or supplies are provided. The Usual and Customary Charge is the charge most frequently made to the majority of patients for the same service or procedure. The charge must be within the range of the charges most frequently made in the same or similar medical service area for the service or procedure as billed by *physicians, healthcare practitioners* or *dentists*.

General Anesthesia

An agent introduced into the body which produces a condition of loss of consciousness.

Genetic Information

The information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Health Care Provider

A *physician*, *practitioner*, *nurse, hospital* or *specialized treatment facility* as those terms are specifically defined in this section.

Home Health Care Agency

An agency or organization that provides a program of home health care and that:

1. is approved as a *home health care agency* under *Medicare*;

2. is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; or

3. meets all of the following requirements:

    a. it is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;

    b. it has a full-time administrator;

    c. it maintains written records of services provided to the patient;

    d. its staff includes at least one registered *nurse* or it has nursing care by a registered *nurse* available; and

    e. its employees are bonded and it provides malpractice and malplacement insurance.

Hospice Care

A program approved by the attending *physician* for care rendered in the home, *outpatient* setting or institutional facility to a terminally ill covered person with a medical prognosis that life expectancy is six (6) months or less.

Hospice Facility

A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill with a medical prognosis that life expectancy is six (6) months or less.

The facility must have an interdisciplinary medical team consisting of at least one (1) *physician*, one (1) registered *nurse*, one (1) social worker, one (1) volunteer and a volunteer program.

A *hospice facility* is not a facility or part thereof which is primarily a place for rest, *custodial care*, the aged, drug addicts, alcoholics, or a hotel or similar institution.

Hospital

The term *hospital* means:

1. an institution constituted, licensed, and operated in accordance with the laws pertaining to *hospitals*, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an *injury* or *illness*, and which provides such treatment for compensation, by or under the supervision of *physicians* on an *inpatient* basis with continuous 24-hour nursing service by registered *nurses*;

2. an institution which qualifies as a *hospital* and a provider of services under *Medicare*, and is accredited as a *hospital* by the Joint Commission on the Accreditation of Health Care Organizations;

3. a *rehabilitation facility*.

The term *hospital* shall also include a *residential treatment* facility specializing in the care and treatment of mental/nervous conditions or substance abuse treatment, provided such facility is duly licensed if licensing is required, or otherwise lawfully operated if licensing is not required.

Regardless of any other Plan provision or definition, the term *hospital* will not include an institution which is other than incidentally, a place of rest, place for the aged or a nursing home.

Illness

Any bodily sickness, disease or mental/nervous disorder. For the purposes of this Plan, pregnancy will be considered an *illness*.

Injury

A condition which results independently of an *illness* and all other causes and is a result of an externally violent force or accident.

Inpatient

Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit

A section, ward, or wing within a *hospital* which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate *nurses* or other highly trained personnel. This excludes, however, any *hospital* facility maintained for the purposes of providing normal post-operative recovery treatment or service.

Late Enrollee

An individual who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Lifetime

The period of time you or your eligible dependents participate in this Plan.

Maintenance Care

Services and supplies primarily to maintain a level of physical or mental function.

Medical Emergency

An *illness* or *injury* which occurs suddenly and unexpectedly, requiring immediate medical care and use of the most accessible *hospital* equipped to furnish care to prevent the death or serious impairment of the covered person.

Such conditions include, but are not limited to, suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsion, or such other acute medical conditions as determined to be *medical emergencies* by the *Plan Administrator*.

Medically Necessary (Medical Necessity)

Any service or supply required for the diagnosis or treatment of an active *illness* or *injury* that is rendered by or under the direct supervision of the attending *physician*, generally accepted by medical professionals in the United States and non-experimental.

Medicare

Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended.

Morbid Obesity

A condition in which the body weight exceeds the normal weight by either 100 pounds, or is twice the normal weight of a person the same height, and conventional weight reduction measures have failed.

The excess weight must cause a medical condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Nurse

A person acting within the scope of his/her license and holding the degree of Registered Graduate *Nurse* (R.N.), Licensed Vocational *Nurse* (L.V.N.) or Licensed Practical *Nurse* (L.P.N.).

Open Enrollment Period

A period of time during the month of November with a coverage effective date of January 1st.

Oral Surgery

Necessary procedures for *surgery* in the oral cavity, including pre- and post-operative care.

Outpatient

Treatment either outside a *hospital* setting or at a *hospital* when room and board charges are not incurred.

Partial Disability

A condition in which, as a result of injury or sickness, a covered person cannot perform some of the duties of his or her usual occupation or from engaging in the occupation on a full-time basis.

Physically or Mentally Handicapped

The inability of a person to be self-sufficient as the result of a condition such as, but not limited to, mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a *physician* as a permanent and continuing condition preventing the individual from being self-sufficient or other *illness* as approved by the *Plan Administrator*.

Physician

A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), and who is legally entitled to practice medicine under the laws of the state or jurisdiction where the services are rendered.

Plan Administrator

The *Plan Administrator*, Skidmore College, is the sole fiduciary of the Plan, and exercises all discretionary authority and control over the administration of the Plan and the management and disposition of the Plan assets. The *Plan Administrator* shall have the sole discretionary authority to determine eligibility for Plan benefits or to construe the terms of the Plan.

The *Plan Administrator* has the right to amend, modify or terminate the Plan in any manner, at any time, regardless of the health status of any Plan participant or beneficiary.

The *Plan Administrator* may hire someone to perform claims processing and other specified services in relation to the Plan. Any such contractor will not be a fiduciary of the Plan and will not exercise any other discretionary authority and responsibility granted to the *Plan Administrator*, as described above.

Plan Sponsor

Skidmore College.

Plan Year

The 12-month period for Skidmore College beginning January 1 and ending December 31.

Practitioner

A *physician* or person acting within the scope of applicable state licensure/certification requirements and/or holding the degree of Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Optician, Certified Nurse Midwife (C.N.M.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Psy.D.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist or Registered Respiratory Therapist.

Pre-Existing Condition

A *pre-existing condition* is a physical or mental condition, regardless of the cause of the condition from which medical advice, diagnosis, care or treatment was recommended or received within a certain period of time ending on the person's *enrollment date*.

Professional Components

Services rendered by a professional technician (e.g. radiologist, pathologist, anesthesiologist) in conjunction with services rendered at a *hospital, ambulatory surgical center* or *physician's* office.

Qualified Medical Child Support Order

A medical child support order that either creates or recognizes the right of an alternate recipient (i.e., a child of a covered participant who is recognized under the order as having a right to be enrolled under the Plan) or assigns to the alternate recipient the right to receive benefits for which a participant or other beneficiary is entitled under the Plan.

A "medical child support order" is a judgment, decree or order (including a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law in that state, that provides for child support related to health benefits with respect to the child of a group health plan participant, or required health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or that enforces a state medical child support law enacted under Section 1908 of the Social Security Act with respect to a group health plan.

Qualifying Exigency

An event arising from your spouse, son, daughter, or parent's call to active duty in the United States Armed Forces. Such exigencies are:

1. Short-Notice Deployment

Leave if your covered family member is notified of a deployment of seven days or less. You may take a leave of up to seven days for any reason related to that deployment. The seven day period begins on the day the covered family member is notified of the short-notice deployment.

2. Military Events

Leave in order to attend any official ceremony, program or event sponsored by the armed forces, and to attend family support and assistance programs and information briefings sponsored by the military, military service organizations, or the American Red Cross.

3. Child Care / School Activities

Leave in order to arrange for child care or attend certain school functions of the son or daughter of a covered military family member, including leave to:

a. Arrange for alternative school or childcare;

b. Provide childcare on an urgent, immediate need (not regular) basis;

c. Enroll or transfer a child into a new school or day care facility; and

d. Attend meetings with school or day care staff regarding discipline, parent-teacher conferences, and school counselors if directly related to the active duty of a covered military family member.

4. Financial And Legal Arrangements

Leave in order to make or update financial or legal arrangements to address the covered military family member's absence while on active duty/call to active duty, such as preparing or executing a will, powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, and securing military service benefits (Leave is not available for routine matters, such as paying bills.)

5. Counseling

Leave in order to attend counseling by a non-health care provider (i.e. military chaplain, pastor, or minister, or counseling offered by the military or a military service organization) available when counseling is needed by the employee, the covered military member, or the son or daughter of the covered military member provided that the counseling arises from active duty service or call to active duty.

6. Rest And Recuperation Leave

Leave in order to spend time with a covered military family member on rest and recuperation leave during a period of deployment. You may take a leave of up to five days during any military family member's rest and recuperation leave.

7. Post-Deployment Activities

Leave in order to attend ceremonies incident to the return of the covered military family member, including arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of ninety (90) days following the termination of the covered military member's active duty status, participation in Department of Defense "Yellow Ribbon Reintegration" Program (participation is permitted even if it exceeds the general ninety (90) day limitations period by a few days).

Additionally, such leave is available to address issues arising from the death of a covered military family member including meeting and recovering the body and making funeral arrangements.

8. Additional Activities

Upon approval by the *Plan Administrator*, any other activity arising from your covered family member's call to or active service duty/contingency operation in the United States Armed Forces.

Rehabilitation Facility

A legally operating institution or distinct part of an institution which has a transfer agreement with one or more *hospitals*, and which is primarily engaged in providing comprehensive multidisciplinary physical restorative services, post acute *hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate governmental agency to provide such services. It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part time care services, or an

institution which primarily provides treatment of mental/nervous conditions, substance abuse treatment or tuberculosis except if such facility is licensed, certified or approved as a *rehabilitative facility* for the treatment of medical conditions, mental/nervous conditions or substance abuse treatment in the jurisdiction where it is located, or is credited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Respite Care

Respite care rendered through a licensed *hospice facility* for home custodial care which provides relief to an immediate family in caring for the day to day needs of a terminally ill individual.

Retiree

A former active employee of the employer who was retired while employed by the employer under the formal written plan of the employer and elects to contribute to the plan the contribution required from the retired employer.

Second Surgical Opinion

Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the diagnosis of the proposed *surgery* to evaluate alternatives and/or the medical advisability of undergoing a surgical procedure.

Significant Break In Coverage

A period of sixty-three (63) or more consecutive days without *creditable coverage*. Periods of no coverage during an HMO affiliation period or *waiting period* shall not be taken into account for purposes of determining whether a *significant break in coverage* has occurred. For this purpose, an HMO affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

Skilled Nursing Facility/Extended Care Facility/Convalescent Nursing Hospital

An institution that:

1. primarily provides skilled (as opposed to custodial) nursing service to patients;

2. is approved by the Joint Commission on the Accreditation of Healthcare Organizations (JCAH) and/or *Medicare*.

In no event shall such term include any institution or part thereof that is used principally as a rest facility or facility for the aged or, any treatment facility for mental/nervous condition or substance abuse treatment.

Special Enrollee

A Special Enrollee i**s** an employee or dependent who is entitled to and who requests special enrollment:

a. within thirty-one (31) days of losing other health coverage because their COBRA coverage is exhausted, they cease to be eligible for other coverage, or employer contributions are terminated;

b. for a newly acquired dependent, within thirty-one (31) days of the marriage, birth, adoption, or placement for adoption; or

c. an employee or dependent who is entitled to and who requests special enrollment within sixty (60) days of losing other health coverage through Medicaid or CHIP.

d. for a *transitional rule dependent* who is entitled to and who requests special enrollment within thirty (30) days of receiving a written notification.

Specialized Treatment Facility

Specialized treatment facilities as the term relates to this Plan include *birthing centers, ambulatory surgical facilities, hospice facilities,* or *skilled nursing facilities* as those terms are specifically defined.

Surgery

Any operative or diagnostic procedure performed in the treatment of an *injury* or *illness* by instrument or cutting procedure through any natural body opening or incision.

Total Disability (Totally Disabled)

The inability to perform all the duties of the covered person's occupation as the result of an *illness* or *injury*. *Total disability* means the inability to perform the normal duties of a person of the same age.

Transitional Rule Dependent

A single or married dependent beneficiary who is under the age of twenty-six (26) and was previously enrolled in the plan and their eligibility was terminated due to age; or was previously not eligible under the plan when the employee first became eligible as the child's age at that time exceeded the Plan limitation.

If the dependent beneficiary is under the age of twenty-six (26) and eligible for other employer-sponsored health coverage, they may not waive the available employer-sponsored coverage in order to enroll under this Plan.

Waiting Period

A period of continuous, full-time employment before an employee or dependent is eligible to enroll in the Plan, or for purposes of determining *creditable coverage*, the *waiting period* under any other health plan.

Year

See *calendar year*.

ARTICLE XIV -- GENERAL INFORMATION

Name and Address of the Plan Sponsor

Skidmore College
815 North Broadway
Saratoga Springs, NY 12866

Name and Address of the Plan Administrator

Skidmore College
815 North Broadway
Saratoga Springs, NY 12866

Name and Address of the Agent for Service of Legal Process

Skidmore College
815 North Broadway
Saratoga Springs, NY 12866

Claims Administrator

BlueShield of Northeastern New York
P.O. Box 80
Buffalo, NY 14240-0080

Internal Revenue Service and Plan Identification Number

The corporate tax identification number assigned by the Internal Revenue Service is 14-1514576. The plan number is 501.

Plan Year

The twelve (12) month period for Skidmore College beginning January 1 and ending December 31.

Method of Funding Benefits

The funding for the benefits is derived from the funds of the *employer* and contributions made by covered employees. The Plan is not insured.

Plan Modification And Termination

The *Plan Administrator* intends to continue the Plan indefinitely. Nevertheless, Skidmore College reserves the right to amend, modify, or terminate the Plan at any time, which may result in the termination or modification of your coverage. The *Plan Administrator* will notify all covered persons as soon as possible, but in no event later than sixty (60) days after the effective date the plan change was adopted. Expenses incurred prior to the Plan termination, modification or amendment will be paid as provided under the terms of the Plan prior to its termination, modification or amendment.

Discretion of Plan Administrator

The *Plan Administrator* shall be the sole determiner of all matters concerning medical benefits and coverage under this Plan. The *Plan Administrator* shall have broad discretion in interpreting the provisions of this Plan, which discretion shall be exercised in good faith. The *Plan Administrator's* discretionary authority includes, but is not limited to, resolving questions of coverage and benefits, determining matters relating to eligibility, deciding questions of administration, and deciding other questions under the Plan.

ARTICLE XV -- ERISA STATEMENT OF RIGHTS
(Employee Retirement Income Security Act of 1974)

As a participant in the Skidmore College Employee Benefit Plan, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the *Plan Administrator's* office and at other specified locations, all plan documents, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports.

2. Obtain copies of all plan documents and other Plan information upon written request to the *Plan Administrator*. The Administrator may make a reasonable charge for the copies.

3. In some cases, the law may require the *Plan Administrator* to provide you with a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who operate the plan. These people are called fiduciaries and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your *employer*, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the *Plan Administrator* review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you make a written request for materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the *Plan Administrator* to provide the materials, and pay up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator.*

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file a suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the *Plan Administrator*. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

SIGNATURE PAGE

The effective date of the Skidmore College Employee Benefit Plan is January 1, 2011.

It is agreed by Skidmore College that the provisions of this document are correct and will be the basis for the administration of the Skidmore College Employee Benefit Plan.

Dated this _____ day of _____, _____

BY: _____

TITLE: _____

WITNESS: _____

TITLE: _____