UNIVERSITY MEDICAL RESIDENT SERVICES, P.C.
UNIVERSITY DENTAL RESIDENT SERVICES, P.C.

EMPLOYEE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

EFFECTIVE JUNE 1, 2008

AS RESTATED EFFECTIVE JUNE 1, 2020

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SCHEDULE OF MEDICAL BENEFITS CLASS 0001			
	In-Network	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
Co-Pay	$20	Not applicable	The co-pay is waived for dependents under age 19 when services are rendered by a primary care physician.
Individual Deductible	$0	$1,000	For family plans, if any family member reaches their individual deductible amount, then the deductible is satisfied for that one family member. When any combination of family members reach the family deductible, then the deductible is satisfied for the entire family. However, no one family member can contribute more than their individual deductible toward the family deductible amount.
Family Deductible	$0	$2,000	
Coinsurance	100%	75%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	$5,000	$10,000	Includes medical & prescription drug deductible, co-pays & coinsurance amounts. Once a member reaches their individual out-of-pocket maximum amount, the plan will begin to pay at 100%. If you are enrolled in family coverage, the remainder of the family out-of-pocket amount can be satisfied by any one or more covered family members. However, no one family member can contribute more than their individual out-of-pocket amount toward the family out-of-pocket amount. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	$10,000	$20,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise. √ Maximums are combined for in-network and out-of-network services. √ Medical care provided outside the United States is limited to treatment of a medical emergency.			

Medical Plan – Class 0001	In-Network	Out-Of-Network	Limitations and Explanations
Allergy Injections	100%	75%*	No co-pay for allergy serum.
Allergy Testing	100% after $20 co-pay	75%*	
Ambulance - Ground / Air	100% after $50 co-pay	100% after $50 co-pay	
Anesthesia	100%	75%*	Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
Artificial Insemination - Office	100% after $20 co-pay	75%*	Follows Infertility Guidelines.
Artificial Insemination – Outpatient	100% after $75 co-pay	75%*	Follows Infertility Guidelines. The co-pay is waived if services are performed by an affiliated hospital.
Cardiac Rehabilitation	100% after $20 co-pay	75%*	Limited to 24 visits per episode in a 12-week period per plan year.
Chemotherapy / Radiation Therapy	100% after $20 co-pay	75%*	
Chiropractic Care	100% after $20 co-pay	75%*	Precertification is required when services are rendered by a chiropractor.
Diabetic Education	100% after $20 co-pay	75%*	Precertification is required for home education.
Diabetic Equipment & Supplies	100% after $20 co-pay	75%*	
Diagnostic MRI / MRA / PET / CT	100% after $100 co-pay	75%*	Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
Diagnostic Testing – Laboratory	100%	75%*	
Diagnostic Testing – Radiology	100% after $20 co-pay	75%*	Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
Dialysis	100%	75%*	
*Deductible applies			

Medical Plan – Class 0001	In-Network	Out-Of-Network	Limitations and Explanations
Durable Medical Equipment	50%	50%*	Precertification is required for select equipment.
Emergency Room	100% after $150 co-pay	100% after $150 co-pay	Co-pay waived if admitted.
Hearing Examination	100% after $20 co-pay	75%*	
Home Health Care	100% after $20 co-pay	75%*	Precertification is required for home health aide. Out-of-network services are limited to 365 visits per plan year, reduced by in-network visits.
Hospice Care	100%	75%*	Bereavement counseling is included.
Hospital - Inpatient Acute Physical Rehabilitation Facility	100% after $250 co-pay	75%*	Precertification is required. Limited to 45 days per plan year. The co-pay is waived if services are performed by an affiliated hospital.
Hospital - Inpatient Treatment of Mental Health & Substance Abuse	100%	75%*	
Hospital - Inpatient Treatment Of Other Covered Conditions	100% after $250 co-pay	75%*	Precertification is required. The co-pay is waived if services are performed by an affiliated hospital.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $75 co-pay	75%*	Precertification is required for select procedures. The co-pay is waived if services are performed by an affiliated hospital.
Hospital - Pre-Admission Testing	100%	75%*	Should be performed within 7 days prior to admission.
Infusion Therapy – Home	100%	75%*	
Infusion Therapy – Outpatient	100% after $20 co-pay	75%*	
Medical Supplies	100%	75%*	
Orthotics & External Prosthetics	80%	Not covered	Precertification is required for select items.
Outpatient Therapy – Mental Health & Substance Abuse	100% after $20 co-pay	75%*	
*Deductible applies			

Medical Plan – Class 0001	In-Network	Out-Of-Network	Limitations and Explanations
Physician Visit - Emergency Room	100%	100%	
Physician Visit - Office / Clinic / Home	100% after $20 co-pay	75%*	The co-pay is waived for dependents under age 19 when services are rendered by a primary care physician.
Physician Visit - Inpatient	100%	75%*	Out-of-network consultations are limited to 2 per admission. Out-of-network visits are limited to 1 per day per condition. Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
Physician - Inpatient Surgeon	100%	75%*	Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	75%*	
Physician - Office Surgeon	100% after $20 co-pay	75%*	
Physician - Assistant Surgeon	100%	75%*	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%	75%*	Limited to 1 per affected breast per plan year.
Post-Mastectomy Surgical Bra	100%	75%*	Limited to 4 per plan year.
Preventive Care	100%	75%*	Includes all mandated care under the Patient Protection and Affordable Care Act (PPACA). Includes prostate screening. Not all preventive services are covered out-of-network.
*Deductible applies			

Medical Plan – Class 0001	In-Network	Out-Of-Network	Limitations and Explanations
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $20 co-pay	75%*	Limited to an aggregate of 20 visits per plan year.
Rehabilitative Therapy – Respiratory	100% after $20 co-pay	75%*	
Skilled Nursing Facility	100%	75%*	Precertification is required. Limited to 50 days per plan year.
Sleep Studies	100% after $20 co-pay	75%*	
Urgent Care Center	10% after $50 co-pay	75%*	
Vision Examination	100% after $20 co-pay	75%*	Limited to 1 exam per every 2-year period; 1 per year with document refractive error for ages 14 and under.
All Other Covered Expenses	100% after applicable co-pay	75%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF PRESCRIPTION DRUG BENEFITS CLASS 0001			
	Pharmacy	Mail Order	Limitations and Explanations
Generic Drug Co-pay	$5	$12.50	Certain medications considered preventive care under the Affordable Care Act (ACA) are payable at a $0 co-pay to the member. Smoking cessation medications are limited to a 180-day supply in any 365-day period.
Formulary Brand Drug Co-pay	$30	$75	
Non-Formulary Brand Drug Co-pay	$50	$125	
Maximum Supply	30 days	Up to 90-day Supply*	
*Days supply less than 90 days dispensed at mail order may be pro-rated to the appropriate co-pay.			

SCHEDULE OF MEDICAL BENEFITS CLASS 0002	In-Network	Out-of-Network	Limitations and Explanations
Individual Lifetime Maximum Benefit	Unlimited		
Co-Pay	$20	Not applicable	The co-pay is waived for dependents under age 19 when services are rendered by a primary care physician.
Individual Deductible	$0	$1,000	For family plans, if any family member reaches their individual deductible amount, then the deductible is satisfied for that one family member. When any combination of family members reach the family deductible, then the deductible is satisfied for the entire family. However, no one family member can contribute more than their individual deductible toward the family deductible amount.
Family Deductible	$0	$2,000	
Coinsurance	100%	75%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	$5,000	$10,000	Includes medical & prescription drug deductible, co-pays & coinsurance amounts. Once a member reaches their individual out-of-pocket maximum amount, the plan will begin to pay at 100%. If you are enrolled in family coverage, the remainder of the family out-of-pocket amount can be satisfied by any one or more covered family members. However, no one family member can contribute more than their individual out-of-pocket amount toward the family out-of-pocket amount. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	$10,000	$20,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise. √ Maximums are combined for in-network and out-of-network services. √ Medical care provided outside the United States is limited to treatment of a medical emergency.			

Medical Plan – Class 0002	In-Network	Out-Of-Network	Limitations and Explanations
Allergy Injections	100%	75%*	No co-pay for allergy serum.
Allergy Testing	100% after $20 co-pay	75%*	
Ambulance - Ground / Air	100% after $50 co-pay	100% after $50 co-pay	
Anesthesia	100%	75%*	Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
Artificial Insemination - Office	100% after $20 co-pay	75%*	Follows Infertility Guidelines.
Artificial Insemination – Outpatient	100% after $75 co-pay	75%*	Follows Infertility Guidelines. The co-pay is waived if services are performed by an affiliated hospital.
Cardiac Rehabilitation	100% after $20 co-pay	75%*	Limited to 24 visits per episode in a 12-week period per plan year.
Chemotherapy / Radiation Therapy	100% after $20 co-pay	75%*	
Chiropractic Care	100% after $20 co-pay	75%*	Precertification is required when services are rendered by a chiropractor.
Diabetic Education	100% after $20 co-pay	75%*	Precertification is required for home education.
Diabetic Equipment & Supplies	100% after $20 co-pay	75%*	
Diagnostic MRI / MRA / PET / CT	100% after $100 co-pay	75%*	Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
Diagnostic Testing – Laboratory	100%	75%*	
Diagnostic Testing – Radiology	100% after $20 co-pay	75%*	Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
Dialysis	100%	75%*	
*Deductible applies			

Medical Plan – Class 0002	In-Network	Out-Of-Network	Limitations and Explanations
Durable Medical Equipment	50%	50%*	Precertification is required for select equipment.
Emergency Room	100% after $150 co-pay	100% after $150 co-pay	Co-pay waived if admitted.
Hearing Examination	100% after $20 co-pay	75%*	
Home Health Care	100% after $20 co-pay	75%*	Precertification is required for home health aide. Out-of-network services are limited to 365 visits per plan year, reduced by in-network visits.
Hospice Care	100%	75%*	Bereavement counseling is included.
Hospital - Inpatient Acute Physical Rehabilitation Facility	100% after $250 co-pay	75%*	Precertification is required. Limited to 45 days per plan year. The co-pay is waived if services are performed by an affiliated hospital.
Hospital - Inpatient Treatment of Mental Health & Substance Abuse	100%	75%*	
Hospital - Inpatient Treatment Of Other Covered Conditions	100% after $250 co-pay	75%*	Precertification is required. The co-pay is waived if services are performed by an affiliated hospital.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $75 co-pay	75%*	Precertification is required for select procedures. The co-pay is waived if services are performed by an affiliated hospital.
Hospital - Pre-Admission Testing	100%	75%*	Should be performed within 7 days prior to admission.
Infusion Therapy – Home	100%	75%*	
Infusion Therapy – Outpatient	100% after $20 co-pay	75%*	
Medical Supplies	100%	75%*	
Orthotics & External Prosthetics	80%	Not covered	Precertification is required for select items.
Outpatient Therapy – Mental Health & Substance Abuse	100% after $20 co-pay	75%*	
*Deductible applies			

Medical Plan – Class 0002	In-Network	Out-Of-Network	Limitations and Explanations
Physician Visit - Emergency Room	100%	100%	
Physician Visit - Office / Clinic / Home	100% after $20 co-pay	75%*	The co-pay is waived for dependents under age 19 when services are rendered by a primary care physician.
Physician Visit - Inpatient	100%	75%*	Out-of-network consultations are limited to 2 per admission. Out-of-network visits are limited to 1 per day per condition. Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
Physician - Inpatient Surgeon	100%	75%*	Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	75%*	
Physician - Office Surgeon	100% after $20 co-pay	75%*	
Physician - Assistant Surgeon	100%	75%*	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%	75%*	Limited to 1 per affected breast per plan year.
Post-Mastectomy Surgical Bra	100%	75%*	Limited to 4 per plan year.
Preventive Care	100%	75%*	Includes all mandated care under the Patient Protection and Affordable Care Act (PPACA). Includes prostate screening. Not all preventive services are covered out-of-network.
*Deductible applies			

Medical Plan – Class 0002	In-Network	Out-Of-Network	Limitations and Explanations
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $20 co-pay	75%*	Limited to an aggregate of 20 visits per plan year.
Rehabilitative Therapy – Respiratory	100% after $20 co-pay	75%*	
Skilled Nursing Facility	100%	75%*	Precertification is required. Limited to 50 days per plan year.
Sleep Studies	100% after $20 co-pay	75%*	
Urgent Care Center	10% after $50 co-pay	75%*	
Vision Examination	100% after $20 co-pay	75%*	Limited to 1 exam per every 2-year period; 1 per year with document refractive error for ages 14 and under.
All Other Covered Expenses	100% after applicable co-pay	75%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF PRESCRIPTION DRUG BENEFITS CLASS 0002			
	Pharmacy	Mail Order	Limitations and Explanations
Generic Drug Co-pay	$5	$12.50	Certain medications considered preventive care under the Affordable Care Act (ACA) are payable at a $0 co-pay to the member. Smoking cessation medications are limited to a 180-day supply in any 365-day period. Fertility drugs are not covered.
Formulary Brand Drug Co-pay	$30	$75	
Non-Formulary Brand Drug Co-pay	$50	$125	
Maximum Supply	30 days	Up to 90-day Supply*	
*Days supply less than 90 days dispensed at mail order may be pro-rated to the appropriate co-pay.			

SCHEDULE OF DENTAL BENEFITS			
Preventive Services	**Participating Provider**	**Non-Participating Provider**	**Limitations and Explanations**
Plan Year Individual Deductible	$50		deductible amount each plan year before this plan starts to pay for covered services you use. The deductible does not apply to preventive and diagnostic services. The family deductible applies collectively to all covered persons in the same family.
Plan Year Family Deductible	$150		
Individual Plan Year Maximum	$1,250		
Preventive and Diagnostic Services	100%	100%	Preventive and Diagnostic Services include oral examination, x-rays, cleaning, sealant, space maintainer and are subject to the limitations described in the article entitled Dental Benefits.
Basic Services	80%*	80%*	Basic Services include fillings, inlays and onlays, repair and relining of dentures, repair of crowns and bridges, endodontic treatment, periodontic treatment, and oral surgery and are subject to the limitations described in the article entitled Dental Benefits.
Major Services	50%*	50%*	Major Services include crowns, dentures, bridgework and are subject to the limitations described in the article entitled Dental Benefits.
* Deductible Applies			

UNIVERSITY MEDICAL RESIDENT SERVICES, P.C.
UNIVERSITY DENTAL RESIDENT SERVICES, P.C.
EMPLOYEE BENEFIT PLAN

ADOPTION OF THE SUMMARY PLAN DESCRIPTION

The Summary Plan Description, dated June 1, 2020, hereby restates the current SPD for the University Medical Resident Services, P.C. and University Dental Resident Services, P.C. Employee Benefit Plan effective .as of June 1, 2020 ("Effective Date").

IN WITNESS WHEREOF, the Plan Sponsor, as Plan Administrator, has caused this SPD to be adopted as of the Effective Date.

University Medical Resident Services, P.C. and
University Dental Resident Services, P.C.

Signature: Joyce Wienke

Print Name: Joyce Wienke

Title: Director, Human Resources

INTRODUCTION

The *plan administrator* 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 SPD describes the provisions of the Plan as of July 1, 2020.

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 *benefit year* which is the 12-month period beginning July 1 and ending June 30. All annual benefit maximums and deductibles accumulate during the *benefit year*. The word *lifetime* as used in this document refers to the period of time a covered person is a participant in this Plan.

Plan Changes - Termination

The *plan sponsor* reserves the right to eliminate benefits and terminate or change the Plan at any time and for any reason. Consistent with its right to amend or terminate the Plan, the *plan sponsor* makes no promise to continue benefits in the future and rights to future benefits do not vest.

To constitute a valid amendment, an amendment must be in writing and must, by its terms, evidence the intent to effect a change in the Plan. Any amendment of this SPD constitutes a valid amendment of the Plan. Oral statements regardless of source cannot alter the terms of the Plan or create benefits that are not provided under the terms of the Plan.

Any discontinuance or modification of the Plan cannot adversely affect valid claims for benefits incurred by eligible persons to the extent the claims were incurred prior to the date of discontinuance or modification. Those valid claims will be paid under the terms of the Plan that were in place prior to the modification, amendment or termination.

Protecting Your Right To Benefits

Important

You are responsible for decisions affecting your participation in the Plan. No one else can make these decisions for you. You can't be sure you are receiving all of the Plan benefits for which you are eligible unless you know what those benefits are, and you follow the Plan's rules for obtaining those benefits. In this Section we discuss some of the most important steps you need to take to ensure that you do not lose or forfeit Plan benefits .

1) Claim and Appeal Procedures

If an employee, participant, or any other person believes he or she is entitled to a Plan benefit, the person must file a claim for benefits with the *claims processor* in accordance with the Plan's internal claim procedures.

Article X of this SPD explains the Plan's claims procedure. Please review **Article X** carefully if you believe that you (or a family member) has been denied a right or benefit under the Plan.

The *claims processor* is the person or entity responsible for determining an enrolled person's entitlement to benefits, and for administering the Plan's disputed claims procedure. As such, the *claims processor* is a fiduciary of the Plan.

The *claims processor* is vested with the authority to determine whether benefit claims qualify for payment under the terms of the Plan.

The *claims processor* also receives and reviews, and decides appeals of denied benefit claims in accordance with the complaint and appeals procedures adopted as part of the Plan.

In exercising this authority, the *claims processor* has the authority and discretion to construe the terms of the Plan and to determine all questions (including questions of fact) arising in connection with determination of claims, and appeals of disputed claims.

Benefits under the Plan will be paid only if the *claims processor* decides, in its discretion, that the claimant is entitled to them.

The Plan's internal claims process involves the following steps:

- The filing of a claim for coverage or benefits by the claims filing deadline.
- If a claim is partially or entirely denied, the filing of an appeal by the appeal deadline.
- If a first appeal is partially or entirely denied, the filing of a second appeal by the second appeal deadline.
- The filing of a request for external review, if applicable.

Once you have exhausted the Plan's claims procedure, you may have the right to file suit, provided you file by the deadline set forth in the Plan. See **Article XIV** ("Legal Actions").

Important

If you fail to comply with the Plan's internal claims process, you will be deemed to have waived and forfeited the right or benefit that you believe has been denied, including the right to seek court review of the Plan's decision.

2) Provide Timely Notice of Family Status and Other Election Change Events

Every year, changes affect the personal status of employees, former employees, and their dependents. Marriages, births, adoptions, divorces, and loss of coverage from another source are examples of family status changes that may allow you to make election changes. To make a new election, you must notify the *plan administrator* of the family status or other election change event within **30 days** of the date of the event. The notice deadline is **60 days** if the status change involves a gain or loss of Medicaid or CHIP coverage, a dependent acquired through marriage, or the birth or adoption (or placement for adoption) of a child. **If you fail to meet the notice deadline, you will have to wait until the next open enrollment period to make the change**.

3) Understand Your COBRA Notice Obligations

Under COBRA, employees and their family members who lose group health coverage because of certain life events may be eligible to continue their coverage under the Plan's group health benefits, at their own expense and for limited periods of time. COBRA is discussed in more detail in **Article XI**.

COBRA imposes various notice obligations on employees and other COBRA-eligible individuals. **Failure to meet COBRA notice requirements can result in the loss of the right to continue medical and other group health plan coverage under COBRA.**

When Notice is Required

If you and one or more family members are enrolled in this Plan, you or a family member must notify the COBRA Administrator as soon as possible after the occurrence of one of the following events:

- Your spouse or dependent child ceases to be a legal resident of the United States or Canada;
- Your divorce;
- Your legal separation from your spouse pursuant to a court order of separation;
- A child loses dependent status under the terms of the Plan (e.g., attains age 26);
- The Social Security Administration determines that that you or a family member is entitled to federal disability benefits; or

- You or a family member is (or becomes) entitled to Medicare.

Notice Deadline

As a general rule, notice must be provided as soon as possible but in no event later than **60 days** after the date on which the event occurs (e.g., the date of a divorce or the date of a child's 26th birthday).

How to Provide Notice

The COBRA notice must be provided in one of the following ways:

- Via *first class mail* at the following address:

  Premium Address
  GIS Benefits
  P.O. Box 1806
  San Antonio, TX 78296-1806

  Mailing Address
  GIS Benefits
  P.O. Box 9039
  Austin, TX 78766

- Via *e mail* at: service@gisadmin.net

- Via *fax* to: (512) 583-3262

The notice must contain your name and address, the name and address of any affected persons and a description of the qualifying event. You may be asked to provide additional information after you have submitted the notice.

If these procedures are not followed, your former spouse or your dependent child (as the case may be) will lose the right to elect COBRA coverage.

4) Do Not Rely On Verbal Statements About Your Benefits

Your rights and benefits under the Plan are governed by the official plan document, which includes this SPD. While your employer has made arrangements with various vendors to assist you with your benefits questions, you should not rely on any verbal information from any person or vendor. Information provided verbally cannot alter the terms of the Plan, or create benefits that are not provided under the terms of the Plan. **If you have an important question regarding a Plan benefit, you should read this SPD. If you still have a question, submit your question, in writing, to the *plan administrator*.**

5) You and Your Spouse Should Consider Enrolling in Medicare When First Eligible

Employees who are eligible for Medicare are eligible for coverage under the Plan on the same terms and conditions as employees who are not eligible for Medicare.

If you are eligible for Medicare, you have the following options:

- you may enroll in the Plan and enroll in Medicare Parts B and D (or C) when your "current employment status" ends;

- you may enroll in Medicare Parts B and D (or C) and drop your coverage under the Plan; or

- you may enroll in the Plan and also enroll in Medicare.

If you are eligible for Medicare (but not enrolled) when your "current employment status" ends, and your Plan coverage will continue (e.g., pursuant to a severance arrangement, early retirement plan or COBRA), you will need to enroll in Medicare to avoid a significant gap in your medical coverage. If your spouse is Medicare-eligible, your spouse will also need to enroll in Medicare to avoid a significant gap in coverage.

If you (and your Medicare-eligible spouse) fail to enroll in Medicare when your "current employment status" ends, the Plan <u>will not</u> pay for any medical expense incurred by you or your dependents to the extent the expense would have been covered by Medicare.

Employees who are not actively working have "current employment status" provided their employment has not been terminated; their employer-provided disability benefits, if any, do not extend for more than 6 months; they are not entitled to Social Security disability benefits; and their coverage under the Plan is not COBRA coverage.

<u>Information About Medicare</u>

For more information about your Medicare rights and obligations, you should visit the following publications regarding Medicare: Your Guide to Who Pays First, available at: http://www.medicare.gov/Pubs/pdf/02179.pdf. For detailed booklets on Medicare topics visit: www.medicare.gov. You can also obtain information on Medicare Coordination of Benefits by calling 1-855-798-2627.

6) <u>Keep the Plan Administrator Apprised of Changes in Personal Information</u>

It is critically important for you to keep the *plan administrator* apprised of any change in your name or address, or the name and address of your spouse or any of your children. Important benefits information may be mailed to you at the address in the *plan administrator's* records. This information may include important changes in benefits, and important notices apprising you of your rights and responsibilities under the Plan. This information also may include passwords and other personal information that, if known to another person, might enable unauthorized access to personal and benefits information.

7) <u>Know Whether You Need to Obtain Preauthorization for Medical Care</u>

Certain medical and dental services, such as inpatient stays, certain tests, procedures and outpatient surgery require precertification by the Plan's Claims Administrator. See **Article II**. You should ensure that your health care provider obtains the proper authorization

before providing care. **It is always your responsibility to obtain preapproval when services are going to be provided by an out-of-network provider. Failure to obtain precertification can result in a denial or reduction in your medical plan benefits leaving you fully or partly responsible for your medical bills.**

8) Know Whether Your Health Care Provider is In-Network

You can receive your health care from in-network providers or out-of-network providers.

Visit www.bcbswny.com/content/wny/find-a-doctor/dental.html for a listing of the Plan's in-network dental providers. A listing of the Plan's in-network medical providers can be found here www.bcbswny.com/content/wny/find-a-doctor.html.

In-network providers are health care providers (hospitals, physicians, dentists, etc.) who have agreed to accept a negotiated fee for services provided. Your deductibles, copayments, and coinsurance amounts will generally be lower when you use network providers and facilities.

As a general rule, out-of-network providers are free to charge the amounts they deem appropriate for the care they provide, which is likely in all cases to be more than the amount the plan will pay for the same services, leaving you personally liable for provider charges that exceed the amount the Plan will pay. This is referred to as balance billing.

In some cases, your medical plan may permit the use of out-of-network providers at in-network cost sharing if there is no in-network provider that is capable of providing the same service.

Example of Balance Billing

If the out-of-network provider charges $1,000 for a procedure, and the Plan's allowed amount is $500, you will be responsible for paying the difference of $500.

ARTICLE I -- ELIGIBILITY AND PARTICIPATION

A. Who Is Eligible

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

1. On the W-2 payroll of the *plan sponsor*;
2. Enrolled in an accredited resident training program administered by the Office of Graduate Medical Education; and
3. Classified by the *plan sponsor* as "full-time".

Residents in the Child Psychiatry Program administered by the Office of Graduate Medical Education are considered full-time employees and will be treated as eligible employees of the *plan sponsor* at all times during their residency.

Your eligible dependents who reside in the United States or Canada may also participate.

Eligible dependents include:

1. A legal spouse, unless legally separated from you pursuant to a court order.
    a. To be eligible for Plan coverage, your spouse must establish and maintain a legal residence in the United States or Canada.
    b. The *plan administrator* has the right to request proof of an individual's status as a spouse. No person will be eligible for coverage as a spouse unless proof satisfactory to the *plan administrator* has been provided. If your spouse ceases to be a legal resident of the United States or Canada, their coverage under this Plan will end. You are responsible for notifying the *plan administrator* within thirty (30) days after the date your spouse ceases to meet the residency requirement. In no event will coverage be provided for periods during which your spouse did not meet the legal residency requirement.
2. A child from birth to age twenty-six (26).

    The term child includes:

    a. your 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 (and who remains subject to the legal guardianship); and

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.

   The *plan administrator* has the right to request proof of an individual's status as a dependent child. If you do not provide proof satisfactory to the *plan administrator* that a child qualifies as a dependent, you will lose the right to enroll the child. If a dependent child ceases to be a legal resident of the United States or Canada, their coverage under this Plan will end. You are responsible for notifying the *plan administrator* within thirty (30) days after the date your dependent child ceases to meet the residency requirement. In no event will coverage be provided for periods during which your spouse did not meet the legal residency requirement.

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, except as expressly required by law.

B. Who Pays for Your Benefits

Benefits are not insured. Benefits are paid by your employer from Participant contributions and the general assets of the *plan sponsor*.

C. Enrollment Requirements

Employees must enroll themselves and their eligible dependents to have coverage under the Plan. No otherwise eligible person will be enrolled for coverage unless all required enrollment actions are timely and correctly completed in accordance with the enrollment procedures published by the *plan administrator* and *claims processor*. The Plan's enrollment procedures are communicated as part of the Plan's enrollment communications.

Important

To be enrolled for coverage, all elections must be submitted in accordance with all enrollment requirements, in particular, by the deadlines communicated as part of the Plan's enrollment information.

The *plan administrator* may extend the enrollment deadline if the *plan administrator* determines that the necessary enrollment information could not have been provided by the deadline. Extensions will be granted (or denied) in a manner that is uniformly applied to all similarly situated Employees. Unless an extension is granted, you will have no Plan coverage if you fail to submit a complete election by the last day of the applicable enrollment deadline.

D. Initial Enrollment Period

New hires and newly eligible Employees may enroll for coverage during their initial enrollment period. An Employee's initial enrollment period begins and ends on the dates specified in the Plan's enrollment information.

When Coverage Begins

Coverage Plan benefits becomes effective on the first day of your active employment as an eligible employee, assuming all applicable enrollment requirements are satisfied.

Important

If you fail to enroll in medical and dental coverage when you are initially eligible to do so, you will be deemed to have made a "No Coverage" election. Deemed no coverage elections cannot be changed until the next annual open enrollment period, unless you experience an election change event (addressed below).

Dependent Coverage

If you do not enroll your eligible dependents during your initial enrollment period, you must wait until the next annual enrollment period, unless you experience an election change event, as described in this section. Dependents you acquire after your initial enrollment period must be added within 30 days (in some cases, 60 days) following the date the dependent was acquired. See MID-YEAR ELECTION CHANGES (below).

E. Open Enrollment Period

Before the beginning of each Plan Year there is an open enrollment period during which you can make new benefit choices for the next Plan Year. During the open enrollment period, Employees may change existing coverage. Open enrollment is available to active Employees, Employees on a disability, family or personal leave of absence, and COBRA qualified beneficiaries. If properly made, open enrollment elections become effective as of the dates specified in the Plan's open enrollment information (generally, the first day of the following Plan Year). Existing elections (including deemed elections) that are not revoked during the open enrollment period will rollover into the following Plan Year unless otherwise indicated as part of the open enrollment information.

F. Mid-Year Election Changes

As noted above, the elections you make under the Plan (including "deemed" and "rollover" elections) may not be modified until the next annual open enrollment period. However, certain mid-year election changes are permitted as more fully discussed below.

Important

Mid-year election changes are permitted only if the following important requirements are met:

- You or your dependent has experienced a change in status or other event that, in the judgment of the *plan administrator*, constitutes a qualifying election change event;
- The election change request is submitted in the form and manner prescribed by the *plan administrator*;
- The *plan administrator* approves the election change request; and
- The new election is made within 30 days (60 days for some events) following the election change event.

The *plan administrator* reserves the right to evaluate all requests for election changes for consistency, and to ensure requests are handled in accordance with the terms of the Plan and applicable law.

Election change events include the following:

- The Special Medical Plan Enrollment Periods in paragraph G.
- Marriage, divorce, birth, adoption, or death of a spouse or child.
- Change in the eligibility status of a covered dependent.
- Your spouse starts or stops working.
- Your or your spouse have a change in employment status (e.g., full to part-time).
- You or your spouse take an unpaid leave of absence.
- Your spouse's coverage is eliminated due to an employment change.

If properly made, mid-year election changes will become effective no later than the first day of the month following the month in which the election change occurs.

G. Special Enrollment

In addition to the election change events described in Paragraph C, you and your dependents may have special enrollment rights under the following circumstances:

1. You or a dependent becomes eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program. You must request enrollment within **60 days** following the determination of eligibility for State assistance. If elected, coverage will commence no later than the first day of the month following a completed request for enrollment.

2. You are a current Employee or a dependent of a current Employee that is not enrolled in our Plan because of coverage under another qualifying health plan and that other coverage is lost for certain reasons specified by law. If the other coverage is lost as a result of a failure to pay required premiums or contributions or for cause (e.g., making a fraudulent claim), this special enrollment right does not apply. You must request enrollment **within 30 days** following the

loss of other coverage (**60 days** if the loss of coverage is Medicaid or CHIP coverage). If elected, coverage will commence no later than the first day of the month following a completed request for enrollment.

3. Current Employees who get married may enroll themselves, their new spouse and any new dependent children acquired as a result of the marriage. An Employee seeking special enrollment rights under this provision must request enrollment within **60 days** following the date of marriage. If elected, special enrollment coverage will begin no later than the first day of the month following a completed request for enrollment.

4. Current Employees who acquire a new dependent child through birth, adoption or placement for adoption, may enroll themselves, their spouse and the new child. A child is placed with a Participant for adoption if the Participant has taken on the legal obligation for the support of the child whom he or she plans to adopt. An Employee seeking special enrollment rights under this provision must request enrollment within **60 days** following the child's date of birth, adoption or placement for adoption. If elected, coverage will begin on your new child's date of birth, adoption or placement for adoption.

5. If a spouse or eligible dependent child establishes legal residence in the U.S. or Canada, the following election changes are permitted:

   - If the employee is enrolled, he or she may add the spouse, and any dependent child.

   - If the employee is not enrolled, he or she may enroll himself/herself, the spouse, and any dependent child.

   All election forms and other documents required by the *plan administrator* must be submitted within **60 days** of the date on which the spouse (or eligible dependent child) first becomes a legal resident of the U.S. or Canada with coverage effective as of the date on which the dependent first becomes a legal resident.

   Important

   The *plan administrator* has the discretion to determine whether a spouse or eligible dependent child has established legal residence in the U.S. or Canada, and may require the employee, spouse and/or eligible dependent child to sign an affidavit of legal residency, and to submit such other proof relating to the issue of legal residency as the *plan administrator* deems necessary.

H. Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act, or *GINA*, prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of *genetic information*.

Genetic information is a form of protected health information as defined by the Health Insurance Portability and Accountability Act of 1996 (*HIPAA*), and is subject to applicable privacy and security standards.

GINA does not prohibit a *health care provider* who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when necessary to determine whether the treatment provided was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting purposes. Such requests, will be made with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums, or contributions. In addition, the Plan will notify the Health and Human Services secretary of its activities falling within this exception.

I. When Coverage Ends

Coverage under the Plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends. Coverage will end on the first to occur of any of the events described in this Section. Enrolled individuals may have the right to continue coverage under COBRA when their coverage ends. COBRA rights are described in **Article XI**.

Termination of Benefits

Coverage will end if the Plan (or any benefits or coverage under the Plan) is terminated.

Fraud or Misrepresentation

The *plan administrator* will immediately void coverage for any fraud or material misrepresentation made by any person in order to gain eligibility or claim a Plan benefit for any person who is not eligible for Plan eligibility or benefits. If a participant's coverage ends for this reason, coverage will also end for any covered dependents. In the event of fraud or misrepresentation, the Plan is entitled to all remedies provided for in law and equity. This includes but is not limited to, recovery for the charges for benefits provided, attorneys' fees, costs of suit, and interest.

Termination of Employment

Coverage of a participant and his or her spouse and dependents will end if the participant terminates employment.

Change of Employment Status

Coverage of a participant and his or her spouse and dependents will end if the participant ceases to be in a class of employees who are eligible for coverage.

Cancelation of Coverage/Nonpayment of Required Premiums

Plan coverage will end for each covered individual if required contributions have not been paid effective with the first day of the coverage period for which the premium was due.

Death of a Participant

If a participant dies, coverage for a spouse and any dependents will end.

A Dependent Child Ceases to Qualify as a Dependent

A dependent child's coverage will end if he or she ceases to meet the dependent eligibility requirements.

Divorce or Legal Separation

A spouse's coverage will end if the participant and spouse divorce or are legally separated pursuant to a court order. Under no circumstances may coverage for a spouse be extended beyond this date (even if ordered by a court in connection with a divorce proceeding) except as required by COBRA.

Cessation of Active Employment

Except as provided under federal law or the leave policies of the *plan sponsor*, coverage of a participant and his or her spouse and dependent children will end if the participant ceases active employment.

J. Family and Medical Leave Act of 1993 (FMLA)

You have the right to continue Plan coverage while on FMLA leave on the same terms and conditions as if you had continued to work. Coverage during an FMLA leave of absence ends at the end of your approved leave or, if earlier, the date you inform the *plan administrator* that you do not intend to return from your leave. You may cancel your coverage during your leave under the Plan's election change rules. If you elect to cancel your coverage, your coverage will be reinstated prospectively if you return to active employment when your leave ends. Your coverage upon return will be subject to any Plan changes that became effective during your leave. For more information regarding FMLA leave, please refer to your Employee Handbook.

K. Employer Continuation Coverage

If you are on an approved paid leave of absence that does not qualify as FMLA leave, eligibility may continue for twelve (12) consecutive weeks following the date that the paid leave of absence began. Once you are off the payroll, your coverage will end on the last day of the month.

L. The Uniformed Services Employment and Re-employment Rights Act (USERRA)

If your leave is a military leave covered under the requirements of USERRA, your Plan coverage will terminate at the start of your leave subject, however, to your right to continue coverage for up to 24 months. If your military service is less than 31 days, your coverage will be continued on the same terms and conditions as if you had remained an active employee. If your military service is more than 31 days, you will be required to pay the full monthly cost (your share, your employer's share, plus an administrative fee).

ARTICLE II -- MEDICAL MANAGEMENT PROGRAM

A. What Is Medical Management

University Medical Resident Services, P.C. and University Dental Resident Services, P.C. 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.

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 treatment. Any questions pertaining to eligibility, Plan limitations or *fee schedules* should be directed to the customer service department.

Your participating *physician* or *provider* is required to call to obtain certification prior to any service requiring precertification as indicated within the Schedule of Medical Benefits.

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, no benefit will be paid toward treatment that is determined not to be *medically necessary*.

ARTICLE III -- NETWORK PROVISIONS

Laboratory Services

When laboratory services are performed within the BlueCross BlueShield of Western New York operating area, services must be provided by the designated laboratory:

Operating Area	Designated Laboratory
BlueCross BlueShield of Western New York: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties	Quest Diagnostic Laboratory

Exceptions:

Upon receipt of prior approval, laboratory services by a non-designated laboratory provider will be reimbursed at the in-network benefit whenever:

1. Services cannot be performed by the designated laboratory listed above,
2. Services by a non-designated laboratory are medically necessary,
3. Services are performed in the treating *physician's* office,
4. Services are performed in conjunction with treatment in a free-standing surgical facility or *hospital*, or
5. Services performed in an *affiliated hospital* with UMRS/UDRS.

All Other Services

The POS network offers access to participating *health care providers* located within the BlueCross BlueShield of Western New York operating area. The network directory contains a list of all participating *physicians* and *hospitals*. If you have any questions regarding a participating provider, call the telephone number indicated on your identification card.

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:

1. Upon receipt of prior approval, treatment by a non-participating *health care provider* will

be reimbursed at the in-network benefit if:

a. Services cannot be provided by a participating provider.

b. On the effective date of coverage, a patient is in an active course of treatment with a non-participation provider.

c. Service is performed within the first ninety (90) days of coverage and is related to ongoing medical treatment.

d. A patient is in the 2nd or 3rd trimester of pregnancy on the effective date of coverage. In this case, obstetrical services will be covered at the in-network level until completion of a post-partum visit.

e. Service is a second opinion consultation of a cancer diagnosis and the attending *physician* has provided a written referral to a non-participating provider.

f. Service is a follow up visit by the emergency room physician or Urgent Care Physician.

g. Service is an inpatient hospitalization.

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

3. If you receive treatment by a network *health care provider, professional components* by a physician during the encounter will be reimbursed at the in-network benefit level, regardless of whether the provider is a participating provider.

4. *Inpatient* or outpatient services by an assistant surgeon rendered in an in-network facility regardless of whether the provider is participating with the network will be reimbursed at the in-network benefit level.
5. An *inpatient physician* visit rendered in an in-network facility regardless of whether the provider is participating with the network will be reimbursed at the in-network benefit level.

6. An *inpatient physician* consultation rendered in an in-network facility regardless of whether the provider is participating with the network 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 terms. The following terms which apply to your Plan's benefits are commonly included in medical benefit plans but often overlooked or misunderstood.

The *claims processor* is the person or entity responsible for determining an enrolled person's entitlement to benefits, and for administering the Plan's disputed claims procedure. As such, the *claims processor* is a fiduciary of the Plan. The *claims processor* is vested with the authority to determine whether benefit claims qualify for payment under the terms of the Plan. The *claims processor* also receives and reviews, and decides appeals of denied benefit claims in accordance with the complaint and appeals procedures adopted as part of the Plan. In exercising this authority, the *claims processor* has the authority and discretion to construe the terms of the Plan and to determine all questions (including questions of fact) arising in connection with determination of claims, and appeals of disputed claims.

Benefits under the Plan will be paid only if the *claims processor* decides, in its discretion, that the claimant is entitled to them.

1. Medical Necessity

   Medically necessary care is care which according to criteria, is:

   - consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury,
   - in accordance with standards of good medical practice,
   - not for your convenience or that of your physician or other provider,
   - the most appropriate supply, level of care, or service which can be safely provided to you.

   The *claims processor* may consult the *Medical Director* in order to determine the *medical necessity* of treatment. Medical treatments which are not proven, effective and appropriate are not covered by this Plan unless specifically mentioned.

2. Fee Schedule

   The Plan provides benefits only for covered expenses that are equal to or less than the *fee schedule* for this Plan. The *fee schedule* for every procedure covered by this Plan may be obtained from the *plan administrator*. The allowable amount for any covered procedure may be changed from time-to-time. If a procedure is not listed in the *fee schedule*, the *Medical Director* will determine the allowance, if any.

3. 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.

4. 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.*

5. Benefit Year

   The word *year,* as used in this document, refers to the *benefit year* which is the 12-month period beginning July 1 and ending June 30. All annual benefit maximums and deductibles accumulate during the *benefit year.*

6. Alternate Benefit Provision

   The *plan administrator* 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 *benefit year* before the Plan will consider expenses for reimbursement. The deductible be satisfied if you and your dependents pay for covered expenses which are incurred for in-network and/or out-of-network services and supplies.

The annual individual and family deductible amounts are shown on the Schedule of Medical Benefits.

C. Deductible Carry-Over

When covered expenses incurred in the last three (3) months of the *benefit year* are applied to the deductible, that amount will also be used to satisfy the deductible for the following *benefit year*.

D. 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 the applicable *fee schedule.*

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

E. Out-of-Pocket Limit

An out-of-pocket limit is the maximum amount of covered expenses you must pay during a *benefit year*. When you reach the annual out-of-pocket limit applicable to you, the Plan will pay one hundred percent (100%) of additional covered expenses during the remainder of that *benefit year.*

The out-of-pocket limit excludes charges in excess of the *allowable amount* and any penalties for failure to comply with the requirements of the Health Care Management Program.

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

F. 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. Any benefit amounts that you or your dependents accumulated toward the benefit maximums and *lifetime* benefit maximums under the University Medical Resident Services, P.C. and University Dental Resident Services, P.C. plan prior to the restatement date of July 1, 2018 will be counted toward the benefit maximums and *lifetime* benefit maximums under this Plan.

G. 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 and Urgent Care Services

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

2. Treatment at an urgent care facility.

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

4. Transportation provided by a professional air ambulance service for the first trip to and from the nearest *hospital* or emergency care facility equipped to treat a condition that can be classified as an *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 health treatment facility, including a residential treatment facility.

5. A substance abuse treatment facility, including a residential treatment facility.

6. A *hospice facility.*

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 schedule* for all other procedures performed.

4. Anesthetic services, when performed in connection with a covered surgical procedure.

5. *Oral surgery*, limited to the removal of tumors and cysts; incisions of sinuses, salivary glands, or ducts; frenectomy; cleft lip and palate; and treatment of an accidental *injury* to sound, 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. Nipple/areola reconstruction and nipple tattooing are also covered when the breast reconstruction is considered eligible under the Plan. This Plan is in compliance with the Women's Health and Cancer Rights Act of 1998.

7. Non-*experimental* 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. This benefit begins on the day of *surgery* and continues for up to ten (10) additional consecutive days. 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 *morbid obesity*.

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

13. Voluntary sterilization.

14. Voluntary termination of pregnancy.

15. Gender reassignment *surgery*, when *medically necessary*, for individuals with a documented diagnosis of gender dysphoria.

Mental/Behavioral Health and Substance Abuse Treatment

1. *Inpatient* mental health treatment.

2. *Inpatient* substance abuse detoxification treatment.

3. Partial hospitalization.

4. *Outpatient* mental health and substance abuse treatment.

5. 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).

6. *Outpatient* treatment of substance abuse codependence.

7. *Outpatient* marriage counseling.

8. *Outpatient* family counseling.

9. Treatment of an eating disorder.

10. Electro-shock therapy.

Medical Services

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

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

3. *Second/third* (if *medically necessary*) *surgical opinions*.

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

5. Services to achieve the diagnosis of infertility.

6. Artificial insemination including sperm washing, hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram (hysterosonography), post coital tests, testis biopsy, semen analysis, blood tests, and ultrasound.

7. 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*.

8. Radiation therapy.

9. Chemotherapy.

10. Hemodialysis.

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

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

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

14. Cardiac rehabilitation therapy received from a qualified *practitioner* under the direct supervision of the attending *physician*.

15. Home health care that is provided by a *home health care agency* (four (4) hours = one (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. nutritional counseling that is provided by or under the supervision of a registered dietician;

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

16. *Hospice care* 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*, 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;

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

17. 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.

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

19. Initial examination for the treatment of eating disorders (e.g., bulimia, anorexia). Subsequent treatment is eligible for consideration as a mental/nervous disorder.

20. Allergy testing and treatment.

21. Preparation of serum and injections for allergies.

22. Sleep studies.

23. 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.

24. Diabetes education programs.

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

26. *Medically necessary* services rendered in connection with an *approved clinical trial.*

27. Diabetes testing and injection supplies, insulin, and other medications for the lowering of blood sugar.

28. Examination for or the purchase or fitting of hearing aids when required as the result of an *injury*.

29. Orthoptic services.

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 and counseling.

Equipment, Supplies and Miscellaneous Items

1. *Durable medical equipment*, including expenses related to necessary repairs and maintenance. A statement is required from the prescribing *physician* determining 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. Initial prescription contact lenses or eye glasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular *surgery* or when required as the result of an *injury*.

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

8. Sterile surgical supplies after *surgery*.

9. Compression garments.

10. Injectible drugs and medicines (including injectible contraceptives), or supplies dispensed through the *physician's* office, for which the patient is charged.

11. Post mastectomy prosthetic and surgical bra.

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

Preventive Care

Preventive care includes the following preventive care items and services as required under the Patient Protection and Affordable Care Act:

1. Evidence-based items or services that have a rating of "A" or "B" and are currently recommended by the U.S. Preventive Services Task Force.

2. Immunizations that are currently recommended by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention.

3. Evidence-informed preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children and adolescents.

4. Additional preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for women.

H. 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. 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.

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

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

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

5. 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.

6. *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.

7. Mailing and/or shipping and handling expenses.

8. 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.

9. Services, supplies, or treatment eligible for consideration under any other plan of the *employer.*

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

11. 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.

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

13. Services or supplies rendered by a facility operated by the Veteran's Health Administration for an *injury* or *illness* determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

14. Medical treatment, supplies or drugs received outside the United States, except for *medical emergencies*.

15. Services, supplies, or treatment incurred as the result of an auto accident up to the amount of any state required automobile insurance with respect to those expenses.

16. Services, supplies, or treatment incurred for services rendered prior to the effective date of coverage under this Plan or expenses for services performed after the date coverage terminates.

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

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

19. Services, supplies, or treatment unnecessary for diagnosis of an *illness* or *injury*, except as specifically mentioned in Covered Medical Expenses.

20. Services, supplies, or treatment used to satisfy Plan deductibles, co-pays, or applied as penalties.

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. Acupuncture and/or acupressure.

2. Adoption expenses.

3. Ambulance transport except as specifically mentioned in Covered Medical Expenses.

4. Blood and storage of self-donated blood, except as specifically mentioned in Covered Medical Expenses.

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

6. *Cosmetic* or reconstructive *surgery* except as specifically mentioned in Covered Medical Expenses.

7. Dental services, extraction of teeth, dental appliances or treatment including hospitalization for dental services, except as specifically mentioned in Covered Medical Expenses.

8. Dispensing fees for drugs, medicines and supplies received in a *physician's* office.

9. Donor expenses except as specifically mentioned in Covered Medical Expenses.

10. Donor organ selection, transportation and storage costs.

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

12. 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, except as specifically mentioned in Covered Medical Expenses.

13. 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*.

14. Eyeglasses or lenses, vision therapy or supplies unless specifically mentioned in Covered Medical Expenses.

15. Foot treatment, palliative or cosmetic, including flat foot conditions, supportive devices for the foot, 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.

16. Gender reassignment *surgery*, except as specified in Covered Medical Expenses.

17. Hearing examinations, hearing aids, or related supplies except as specifically mentioned in Covered Medical Expenses.

18. Holistic medical treatment.

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

20. Hypnosis.

21. Infertility treatment other than artificial insemination services specifically mentioned in the Covered Medical Expenses section.

22. 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*).

23. Massage therapy or rolfing.

24. Non-routine services rendered in connection with an *approved clinical trial*, including:

    - The *experimental* treatment, procedure, device or drug itself.
    - Items or services provided solely to satisfy data collection and analysis.
    - Items or services customarily provided by the research sponsors free of charge.
    - Items or services provided solely to determine trial eligibility.

25. Orthodontics for cleft palate.

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

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

28. Preventive care except as specifically mentioned in Covered Medical Expenses.

29. Private duty nursing.

30. Private room fee except as specifically mentioned in Covered Medical Expenses.

31. *Respite care*.

32. Reversal of any elective surgical procedure.

33. Sales tax.

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

35. Smoking cessation programs or *physician's* office visits for smoking cessation treatment, except to the extent required under the preventive care mandate of the Patient Protection and Affordable Care Act.

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

37. Take home prescription drugs from a *hospital*.

38. Vitamins and nutritional supplements, regardless of whether or not a *physician's* prescription is required, except to the extent required under the preventive care mandate of the Patient Protection and Affordable Care Act.

39. Weight reduction or control, including treatments, instructions, activities, or drugs and diet pills, whether or not prescribed by a *physician*, except as specifically mentioned in Covered Medical Expenses and/or to the extent required under the preventive care mandate of the Patient Protection and Affordable Care Act.

40. Wigs and artificial hair pieces.

ARTICLE V -- PRESCRIPTION DRUG PLAN

A. About Your Prescription Drug Benefits

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

1. Maintenance Medication

   An extended-use medication for which there is a non-emergency ongoing need.

2. Managed Formulary

   A list of approved generic and brand-name prescription and non-prescription drugs.

3. Participating Mail Order Pharmacy

   A pharmacy which has entered into an agreement with the *claims processor* to provide covered mail order prescription drugs.

4. Participating Pharmacy

   A pharmacy which has entered into an agreement with the *claims processor* to provide you covered prescription drugs.

5. Pharmacy Benefits Manager

   A Pharmacy Benefits Manager (PBM) is a third party administrator selected to process outpatient medication bills. The Pharmacy Benefits Manager has been contracted to process prescription drug claims from participating pharmacies. The Pharmacy Benefits Manager also develops and maintains the formulary.

6. Prescription Drug

   A pharmaceutical substance approved by the United States Food And Drug Administration (USFDA) for the treatment of your condition and dispenses in accordance with labeling guidelines. A prescription drug requires a prescription in order to be sold to you, and the label must bear the statement "Caution – Federal Law Prohibits Dispensing without a Prescription."

B. Prior Authorization

Your *physician* is required to obtain prior authorization prior to your purchase of certain medications. To find out if a medication requires prior authorization or the status of a prescription, call your pharmacy benefits manager at the number indicated on your identification card.

C. Mail Order Prescription Drug Program

The mail order prescription drug program is offered when there is an ongoing need for medication. By using this service, you can obtain prescribed medication required on a non-emergency, extended-use basis. The quantity of a prescribed drug ordered through this program can be anything up to a ninety (90) day supply or the equivalent for drugs that are supplied in individual, unit packaging such as aerosols and eye drops.

The law requires that pharmacies dispense the exact quantity prescribed by the *physician*. So, if your *physician* authorizes the maximum order quantity, the prescription must be for a ninety (90) day supply for you to receive that quantity. For example, if you take one (1) tablet per day, your *physician* must write a prescription for ninety (90) tablets. If you take two (2) tablets per day, your *physician* must write a prescription for one hundred and eighty (180) tablets, etc. If your *physician* authorizes refills, these can be dispensed only when your initial order is nearly exhausted, so be sure to ask your *physician* to prescribe the normal supply, plus refills whenever appropriate.

There will be times when you need a new prescription filled immediately. If you need medication immediately but will be taking it on an ongoing basis, ask your *physician* for two (2) prescriptions. The first prescription should be for up to a thirty (30) day supply that you can have filled at a local pharmacy; the second prescription should be for your ongoing need, which will be dispensed in up to a ninety (90) day supply. Send the larger prescription through the mail service prescription drug program.

D. Co-pays

The co-pay amounts are shown on the Schedule of Prescription Drug Benefits.

Exception: The lesser of the prescription drug co-pay or the office visit co-pay applies to diabetic medications. The office visit co-pay will apply to diabetic supplies.

E. Out-of-Pocket Limit

An out-of-pocket limit is the maximum amount of covered expenses you must pay during a *benefit year*. When you reach the annual out-of-pocket limit applicable to you, the Plan will pay one hundred percent (100%) of additional covered expenses during the remainder of that *benefit year.*

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

F. Dispensing Limitations

Prescriptions are covered for up to a thirty (30) day supply, or the equivalent for drugs that are supplied in individual, unit packaging such as aerosols and eye drops, or up to a ninety (90) day supply for certain chronic conditions when authorized by your *physician*. Three (3) co-pays will apply to the purchase of extended cycle oral contraceptives.

The Plan reserves the right to impose additional supply limitations based on relevant medical and/or scientific information available regarding the condition being treated and/or the appropriate medical use of the medication.

Exception: Drugs allowed by New York State law to be dispensed in ninety (90) or one hundred eighty (180) day supply will be dispensed in accordance with the regulation.

One co-pay will apply to each thirty (30) day supply. Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist.

G. Covered Prescription Drugs

Prescriptions covered under your Plan include all drugs bearing the legend "Caution: Federal law prohibits dispensing without a prescription" except as identified in Prescription Drugs Not Covered. In addition, the following are specifically covered by this Plan when accompanied by a *physician's* prescription:

1. Contraceptive drugs and devices, all dosage forms, which are approved by the Federal Drug Administration (FDA) and require a prescription.

2. Diabetic medications, including insulin, glucagon, prefilled insulin pens/cartridges, and prescription oral agents to lower blood sugar.

3. Diabetic supplies, including needles, syringes, test strips, lancets, lancet devices, glucose tablets and alcohol swabs.

4. Infertility medications (Class 0001 only).

5. Impotence medications.

6. Anti-obesity medications, only when prescribed for the treatment of m*orbid obesity*.

7. Acne medications.

8. Smoking deterrents.

9. Prenatal vitamins.

10. Fluoride supplements.

11. Nutritional supplements, limited to *medical necessity*.

12. Prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells.

13. Preventive medications as mandated under the Patient Protection and Affordable Care Act (PPACA).

14. Self-injectable legend drugs, except those listed in Prescription Drugs Not Covered.

15. Compounded medication of which at least one (1) ingredient is a generic legend drug.

16. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a *physician* or other lawful prescriber.

H. Prescription Drugs Not Covered

1. Cosmetic medications, including but not limited to, anti-wrinkle agents, hair growth stimulants, hair removal products and pigmenting/depigmenting agents.

2. Immunization agents.

3. Blood or blood plasma.

4. Vitamins, except as specifically mentioned in Covered Prescription Drugs.

5. Allergy extracts.

6. Anti-obesity medications, except as specifically mentioned in Covered Prescription Drugs.

7. Infusion therapy.

8. Non-legend drugs except as specifically mentioned in Covered Prescription Drugs.

9. Drugs obtained from a non-participating pharmacy.

10. Glucose monitor and calibration solution.

11. Drugs related to the treatment of a non-covered illness, injury or service.

12. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except as specifically mentioned in Covered Prescription Drugs.

13. Charges for the administration or injection of any drug.

14. Replacement of prescription drugs lost or stolen.

15. Prescription level medications for which there is an over-the-counter alternative.

16. Drugs prescribed or dispensed in a manner that is contrary to normal medical practice or outside FDA labeling guidelines, except as required by law.

17. Drugs labeled "Caution: Limited by Federal law to investigational use," or *experimental* drugs even though a charge is made to the individual.

18. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed *hospital*, rest home, sanitarium, *skilled nursing facility*, convalescent *hospital*, nursing home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.

19. Any prescription refilled in excess of the number specified by the *physician*, or any refill dispensed more than one (1) year from the *physician's* original order.

I. Special Care Pharmacy

Some medications treat complex conditions that usually require injection and special handling and are not available through the Mail Order Program. Your *physician* must call 1-800-987-4904 to establish Special Care Pharmacy services. The high-quality services of the Special Care Pharmacy include:

1. Toll-free access to pharmacists 24 hours a day, 7 days a week.
2. Personalized counseling from a highly-trained team of registered nurses and pharmacists.
3. Expedited, scheduled delivery at no extra charge.
4. Refill reminder calls.
5. Free supplies to administer your medication (needles, syringes).
6. Call 1-800-501-7260 Monday to Friday between 8 a.m. and 8 p.m. (Eastern time) for assistance.

ARTICLE VI -- DENTAL BENEFITS

A. About Your Dental Benefits

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

1. Alternate Procedure

   The Plan only provides benefits for the most cost effective treatment of a dental condition which provides a professionally acceptable result as determined by national standards of dental practice.

2. Pre-Treatment Review

   A treatment plan is a written report showing the recommended treatment of any dental disease, defect or injury prepared by the Provider Dentist, or non-provider dentist in the case of covered services outside the service area. If you require any of the following services, a treatment plan must be submitted to HealthNow prior to the performance of services by the Provider Dentist (or the non-provider dentist in the case of covered services outside our Service Area) in order to pre-determine benefits:

   - Crowns.
   - Inlays/onlays.
   - Bridgework.
   - Full or partial dentures.
   - Periodontal *surgery*.

   Within fifteen (15) business days after receipt of all necessary information, HealthNow will notify you and your *dentist*, of the benefits we will cover under this plan when the actual services are performed. Actual benefits will be based on plan provisions and eligibility when services are received.

3. Fee Schedule

   The Plan provides benefits only for covered expenses that are equal to or less than the *fee schedule* for this Plan. The *fee schedule* for every dental procedures covered by this Plan may be obtained from the *plan administrator*. The allowable amount for any covered procedure may be changed from time to-time. If a dental procedure is not listed in the *fee schedule*, the *Medical Director* will determine the allowance, if any.

4. Dental Care Providers

   The Plan provides benefits only for covered services rendered by a *dentist* or *dental hygienist* as those terms are specifically defined in the Definitions section.

5. Benefit Year

   The word *year*, as used in this document, refers to the *benefit year* which is the 12-month period beginning July 1 and ending June 30. All annual benefit maximums and deductibles accumulate during the *benefit year*.

B. Dental Network Provisions

The Dental PPO network offers access to participating dental *health care providers* located within the BlueCross BlueShield of Western New York operating area (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties). The dental network directory contains a list of all participating dental providers. If you have any questions regarding a participating provider, call the telephone number indicated on your identification card.

You may see any dental *health care provider* in or out of the network for covered services whenever you like. However, when you see a dental *health care provider* who is not a participating provider, you are responsible for expenses that exceed the *fee schedule.*

Referrals by participating providers to non-participating providers will be considered as out-of-network services and will be payable at the out-of-network benefit level. In order to have services paid at the in-network benefit level, ask your dental *health care provider* to refer you to a dental PPO participating provider.

C. Deductibles

A deductible is the amount of covered expenses you must pay during each *benefit 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 *benefit year*.

The annual individual and family deductible amounts are shown on the Schedule of Dental Benefits.

D. 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 the *usual and customary charges*. You are responsible for all non-covered expenses and any amount which exceeds the *usual and customary charges* for covered expenses.

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

E. Benefit Maximums

Total plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum for each specific category may apply on any annual or *lifetime* basis. Whenever the word *lifetime* appears in this Plan in reference to benefit maximums, it refers to the time you and your dependents are covered by this Plan.

The benefit maximums applicable to this Plan are shown in the Schedule of Dental Benefits. Any benefit amounts that you or your dependents accumulated toward the benefit maximums and *lifetime* benefit maximums under the University Medical Resident Services, P.C. and University Dental Resident Services, P.C. plan prior to the restatement date of July 1, 2018 will be counted toward the benefit maximums and *lifetime* benefit maximums under this Plan.

F. Covered Dental Expenses

When all of the requirements of this Plan are satisfied, the Plan will provide benefits as outlined on the Schedule of Dental Benefits for the services and supplies listed in this section. A description of any service not listed in this section should be submitted to the *claims processor* for approval prior to treatment.

Diagnostic and Preventive Services

1. Bitewing x-rays - limited to one (1) set of two or four films once in any *benefit year*.

2. Habit breaking mouth guard - including adjustments within the first six (6) months, limited to individuals under age fourteen (14); further limited to one (1) per *lifetime* when received within six (6) months following osseous *surgery.*

3. Intra-oral full mouth series And panoramic x-rays - limited to one (1) in any sixty (60) consecutive month period.

4. Intra-oral periapical films.

5. Occlusal guard / mouth guard – limited to one (1) per lifetime.

6. Oral examinations - limited to two (2) examinations each *benefit year*.

7. Palliative / emergency treatment – treatment of dental pain and minor procedures when no other definitive dental procedures are performed. Any x-ray taken in connection with such treatment is considered a separate dental procedure.

8. Prophylaxis - (cleaning and scaling of teeth) limited to two (2) cleanings in any *benefit year*.

9. Sealants – limited to individuals under the age of sixteen (16), further limited to one (1) in any 36 month period.

10. Space maintainers – limited to individuals under the age of sixteen (16), further limited to one (1) bilateral per arch or one unilateral per quadrant per lifetime.

11. Topical application of fluoride (excluding prophylaxis) - limited to individuals under the age of fourteen (14), further limited to two (2) treatments in any *benefit year*.

Basic Restorative Services

1. Amalgam, silicate, acrylic, plastic or composite fillings.

2. Apicoectomy - limited to one (1) per root canal per lifetime.

3. Bridge / crown / sedative filling re-cementing – limited to one (1) per tooth, further limited to re-cementation performed more than twelve (12) consecutive months after initial insertion.

4. Consultation – limited to one (1) in any twelve (12) consecutive months.

5. Denture / bridge repair - limited to services performed more than six (6) consecutive months after initial insertion.

6. Denture rebase And reline – limited to one per denture in any twenty four (24) consecutive month period, further limited to services performed more than twelve (12) consecutive months after initial insertion.

7. Addition of teeth to an existing partial removable denture or existing fixed bridgework. Benefits are available only when the addition is to replace one (1) or more natural teeth extracted while you are covered under this Plan.

8. Endodontic treatment including root canal therapy.

9. *General anesthesia* when *medically necessary* and administered in connection with a covered oral surgical procedure.

10. Graft, pedicle or free soft tissue - limited to one procedure per quadrant in any thirty six (36) month period.

11. Oral surgery including extraction of teeth.

12. Osseous surgery including scaling and root planning, flap entry, flap closure – limited to one (1) procedure per quadrant in any thirty six (36) month period.

13. Periodontic full mouth debridement – limited to one (1) in any thirty six (36) month period, further limited to a period when no other periodontic treatment has been performed in the previous thirty six (36) month period.

14. Periodontic gingevectomy – limited to one (1) per tooth in any twelve (12) month period, further limited to one per quadrant in any thirty six (36) month period.

15. Periodontic prophylaxis and maintenance – limited to one (1) in any six (6) consecutive month period.

16. Periodontic occlusal adjustment – limited to two visits with the six (6) month period immediately following osseous surgery.

17. Periodontic treatment or *surgery* to remove diseased gum tissue or bone including periodontic prophylaxis.

18. Pulp cap – limited to one (1) per tooth.

19. Scaling and root planning – limited to one (1) per quadrant in any twenty-four (24) month period.

20. Stainless steel temporary crown – limited to one (1) per tooth in any twenty four (24) consecutive month period.

21. Tissue conditioning – limited to one (1) treatment per arch in any twelve (12) month period.

Major Services

1. Crowns.

2. Inlays and onlays.

3. Removable dentures - partial / full initial installation including adjustments during the six (6) consecutive month period following installation.

4. Fixed bridgework - Initial installation including crowns and inlays to form retainers including adjustments during the six (6) consecutive month period following installation.

5. Replacement of an existing partial or full removable denture, or fixed bridgework, by a new partial or full removable denture or new fixed bridgework. Benefits are available only when the replacement includes one (1) or more natural teeth extracted while you are covered under this Plan or the existing denture or bridgework is at least five (5) years old.

G. Dental 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. There may be expenses in addition to those listed below that are not covered by the Plan.

General Exclusions

1. Services rendered by anyone other than a covered *dental care provider*.

2. Any portion of a charge that exceeds the *fee schedule*.

3. Any service or treatment that does not meet the standards accepted by the American Dental Association (ADA).

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

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

6. 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.

7. Any condition or disability sustained as a result of being engaged in any activity primarily for wage, profit, or gain, and could entitle the covered person to a benefit from Worker's Compensation Laws or similar legislation.

8. Services or supplies that are primarily cosmetic, *experimental*, or investigational in nature including, but not limited to, unusual procedures or techniques and personalization or characterization of prosthetic appliances.

9. Expenses for telephone consultations, charges for failure to keep a scheduled appointment, or charges for the completion of dental reports, itemized bills, and claim forms.

10. Mailing and/or shipping and handling charges.

11. Services or supplies rendered by a facility operated by the Veteran's Health Administration for an *injury* or *illness* determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

12. 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.

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

14. Expenses used to satisfy Plan deductibles or applied as penalties.

15. Expenses incurred for services rendered prior to the effective date of coverage under the Plan or expenses for services performed after the date coverage terminates. No payment will be made until services are completed. Crowns, inlays, onlays, bridges, and dentures are considered completed on the date of insertion.

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

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. Athletic mouth guards.

2. Crown, inlay, or onlay restoration if the tooth was prepared before the individual became covered under the Plan.

3. Dentures and/or bridgework, including crowns and inlays forming abutments, if the first

impressions are taken and/or abutment teeth are fully prepared before the individual became covered under the Plan.

4. Duplicate prosthetic devices or appliances.

5. Functional / myofunctional therapy.

6. Gold foil restorations.

7. *Hospital* charges. *Hospital* expenses are covered under the medical portion of this Plan.

8. Implantology and related services.

9. Orthodontic services.

10. Periodontal splinting.

11. Precious metal dentures.

12. Precision or semi-precision attachments.

13. Prescription drugs and medicines.

14. Procedures and appliances to increase vertical dimension or restore occlusion including, but not limited to, equilibration, full mouth rehabilitation, and restoration for malalignment of teeth except as described under covered services.

15. Replacement of lost, stolen, or missing prosthetic devices or appliances.

16. Root canal therapy if the pulp chamber was opened before the individual became covered under the Plan.

17. Sales tax.

18. Temporary dental services will be considered an integral part of the final dental service rather than separate services.

19. Training, educational instruction, or materials relating to dietary counseling, personal oral hygiene, or dental plaque control.

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

21. Veneers.

ARTICLE VII -- COORDINATION OF BENEFITS (COB)

A. General Provisions

When more than one coverage exists, one plan normally pays its benefits in full and the *other plan* pays a reduced benefit. If this Plan is the primary plan, it will consider benefits as if it were the only plan. If this Plan is the secondary plan, it may make additional payment for covered expenses after any applicable deductible, but only to bring the cumulative total paid by both plans combined to the amount that this Plan would have paid if it were the only plan.

For example, assume your spouse's employer plan is primary for your dependent children's expenses. If the expense is $150, a claim for this amount must be submitted first with the spouse's employer plan, which determines a benefit of $120 is payable. Next, a claim for the $150 along with proof of payment of $120 from the spouse's plan should be submitted for payment under this Plan. The benefit under this Plan will be determined as if it was the only Plan. If the benefit under this Plan is $120 or less, no additional benefit is payable. If the benefit payable under this Plan is $135, an additional $15 is payable from this Plan.]

B. Excess Insurance

If at the time of *injury*, sickness, disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

C. Vehicle Limitation

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 vehicle insurance coverage. This Plan will be secondary to any state mandated automobile coverage for services and supplies eligible for consideration under this Plan.

Certain states permit vehicle insurance policyholders to choose personal injury protection (PIP) as a secondary coverage. In states where PIP coverage is available, this Plan will always be considered secondary regardless of the policyholder's election under PIP coverage with the vehicle insurance carrier. Insurance coverages under the names PIP, Med-Pay, First Party Medical and No-Fault are all used interchangeably and refer to a type of first party automobile coverage offering assistance with or direct payment of accident related claims.

Uninsured or underinsured motorist coverage, whether under your policy or not, is subject to recovery by the Plan as a third-party recovery.

D. 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. For more information, see the Medicare and Medicaid sections under Other Important Plan Provisions.

E. Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no *other plan* involved. The secondary and subsequent plans will pay the balance due up to one hundred percent (100%) of the total Allowable Expenses.

F. Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;

2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;

3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

    a. When the parents are separated or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or

b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

   Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any *other plan* which covers the child as a dependent child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

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 VIII -- 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 who might derive financial gain from a settlement agrees:

1. That you will notify the *claims processor* of any settlement with any party and notify the *claims processor* of any lawsuit or claim filed by you or on your behalf, or on behalf of any heirs or otherwise interested parties against any party.

2. To fully cooperate with the terms and conditions of this Plan. If you or your covered dependent, heir or otherwise interested party 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.)

10. That any portion of the lien not satisfied will be deducted from any covered family member's future claims regardless of whether they are accident related. The plan may withhold future benefits from any family member until the lien is repaid.

11. The term settlement or recovery shall include funds recovered through a wrongful death action regardless of whether state law precludes the inclusion of medical expenses as part of the claim.

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 IX -- OTHER IMPORTANT PLAN PROVISIONS

A. Assignment of Benefits

While a claimant may designate a Participating Provider (and for Urgent Care Claims, a Non-Participating Provider) to act as an Authorized Representative, a claimant may not assign his or her benefits to any person or entity, including the claimant's medical plan provider, without the written consent of the *plan administrator*; the *claims processor* does not have the authority to consent to an assignment of benefits. Direct payment to a provider is not evidence of consent to an attempted assignment of benefits.

B. Medicare

Applicable to Active Employees and Their Spouses Ages 65 and Over:

If you remain actively at work after reaching age sixty-five (65), you or your spouse may choose to elect or reject coverage under this Plan. If you or your spouse elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by *Medicare*. If you reject coverage under this Plan, benefits listed herein will not be payable even as secondary coverage to *Medicare*.

Applicable to All Other Participants Eligible for Medicare Benefits:

To the extent required by Federal regulations, this Plan will pay before any *Medicare* benefits. There are some circumstances under which *Medicare* would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described in the Article entitled Coordination of Benefits).

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.

Applicable to Medicare Services Furnished to End Stage Renal Disease (ESRD) Participants Who Are Covered Under This Plan:

If any Plan participant is eligible for *Medicare* benefits because of ESRD, the benefits of this Plan will be determined before *Medicare* benefits for the first eighteen (18) months of *Medicare* entitlement (with respect to charges incurred on or after February 1, 1991 and before August 5, 1997), and for the first thirty (30) months of *Medicare* entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

Applicable to Participants enrolled in a Medicare Part D Plan:

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.

C. 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.

D. 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 excess payments from any individual (including yourself), insurance company, or other organization to whom the excess payments were made or to withhold payment 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.

E. Right to Receive and Release Necessary Information

The *plan administrator* may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the *plan administrator*, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the *plan administrator* shall be free from any liability that may arise with regard to such action. Any participant claiming benefits under this Plan shall furnish to the *plan administrator* such information as requested and as may be necessary to implement this provision.

F. Alternate Payee Provision

Under normal conditions, benefits are payable to you and can only be paid directly to another party upon signed authorization from you. If conditions exist under which a valid release or assignment cannot be obtained, the Plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment.

The Plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the Plan.

Any payment made by the Plan in accordance with this provision will fully release the Plan of its liability to you.

G. 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.

H. Fraud

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of participants being canceled, and such cancellation may be retroactive.

A determination by the Plan that a rescission is warranted will be considered an *adverse benefit determination* for purposes of review and appeal. A participant whose coverage is being rescinded will be provided a 30-day notice period as described under The Patient Protection and Affordable Care Act (PPACA) and regulatory guidance. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

If a participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a participant is aware of any instance of fraud, and fails to bring that fraud to the *plan administrator's* attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the participant and their entire family unit of which the participant is a member.

I. Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

J. No Waiver or Estoppel

All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise, executed by the *plan sponsor*. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

K. Blue Card Pricing Disclosure

When you obtain health care services from a participating provider outside the geographic area BlueCross BlueShield of Western New York and 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 BlueCross and/or BlueShield 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, BlueCross BlueShield of Western New York and 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 BlueCross BlueShield of Western New York and 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 of Western New York and BlueShield of Northeastern New York serves, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area BlueCross BlueShield of Western New York and 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 X -- CLAIM SUBMISSION PROCESS

A. What Is a Claim for Benefits

To receive Plan benefits (i.e., payment for covered medical care) you (or your Authorized Representative) must submit a request for benefits in accordance with the procedures specified in this document.

If your request does not qualify as a Claim, or is not timely filed, you will forfeit your benefits. If your Claim is denied, in whole or in part, you have the right to appeal that decision. Once appealed, the Claims Administrator will provide a full and fair review of your denial. In some cases, you will have the right to have your Claim decided by an External Review Organization.

This document addresses your rights and duties in connection with a Claim for benefits; what you must do to appeal a Claim denial; when your appeal will be decided; and other important information pertaining to the processing of Claims.

Important

Before any Claimant can commence a lawsuit, the Claimant must exhaust his or her rights under the procedure described in this document. A Claimant who fails to exhaust his or her rights under this procedure, will permanently forfeit the right to challenge the Plan's decision in court. A Claimant's lawsuit will not be considered timely unless it is filed within 6 months from the date of the Plan's final decision on appeal.

Definition of "Claim"

A request for benefits will not be treated as a Claim unless it meets all of the following requirements:

- It identifies the Claimant (i.e., it provides the Claimant's Social Security or HICN number);
- It describes the specific medical condition or symptom to which the Claim relates;
- It describes the specific treatment, service or item for which approval or payment is requested;
- With the exception of Urgent Care Claims (which may be submitted orally), the request is submitted in writing (hard copy or electronically); and
- It is received by the Claims Administrator; a request for benefits submitted to any other person or entity will not be treated as a Claim.
- The following are examples of requests and communications that do not qualify as Claims:
- Retail and mail order pharmacy transactions at the point of sale;
- Casual inquiries about benefits, or the circumstances under which benefits will (or will not)

be paid;

- A health provider's request for verification of an individual's eligibility for coverage;
- A request for prior approval of a benefit that does not require prior approval; and
- A request made by a person or entity other than the Claimant or his or her Authorized Representative.

These procedures do not cover claims that relate to eligibility for coverage under the Plan, unless the request for coverage is made in connection with a Claim for a specific Plan benefit (e.g., a request for approval of a medical procedure or payment of medical expenses already incurred).

Important

Your employer's medical plan does not provide medical care; the Plan pays for medical care that is covered by the Plan. A "Claim," therefore, is a request for payment for medical care, not for access to medical care. If the Plan requires that you seek prior approval for a certain treatment, procedure, or item, and you do not receive approval, this means the Plan may not agree to pay for it. You can appeal this decision. If the care you need is urgent, there is an expedited determination process that the *claims processor* must follow. If you or your provider do not believe you can afford to wait for the administrative process to play out, you should go ahead and receive the medical care. You may then submit a Claim for payment after the services are provided (i.e., a Post-Service Claim).

Your Authorized Representative

With one important exception, you may authorize a third party (e.g., your medical provider) to serve as your representative for purposes of submitting Claims and appealing denied Claims. The *claims processor* reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Claimant.

Non-Participating Providers May Not be Authorized Representatives

You may not choose a Non-Participating Provider as your Authorized Representative, unless the Claim qualifies as an Urgent Care Claim. For Urgent Care Claims, the *claims processor* will permit a doctor or other health care professional who has knowledge of your medical condition to act as your Authorized Representative even in the absence of a written designation.

Pre-Service Claims:

Pre-service claims are claims for which advance approval is required. Pre-service claims may be submitted by telephone or in writing.

Refer to your medical ID card for contact information.

Post-Service Claims:

A post-service claim is defined as any request for Plan benefits that complies with the Plan's procedure for making a claim for benefits. A participating *health care provider* will submit a claim directly to the Plan on your behalf. If you desire Plan benefits, you must submit a claim when services are rendered by a *health care provider* that does not participate in the network.

A claim for benefits includes:

1. Employee information: name, address, plan name, group number.

2. Patient information: patient name, address, birth date.

3. Treatment information: date(s) of service, procedure code, description of each supply or service, diagnosis code, charge for each supply or service.

4. *Health care provider* information: name, address, telephone number, federal tax identification number.

Send the complete claim for benefits to the address indicated on your ID card.

The *claims processor* will determine if enough information has been submitted to enable proper consideration of the claim for benefits. If not, more information may be requested from the claimant.

The *claims processor* reserves the right to have a Plan participant seek a second medical opinion.

B. When a Claim for Benefits Should Be Filed

Pre-Service Claim:

When precertification of a claim is required, you should follow the procedures outlined in the Health Care Management Program article of this Plan.

If you desire a predetermination of Plan benefits, you should notify the *claims processor* at least 15 calendar days prior to receiving services.

Post-Service Claims:

A claim for benefits must be filed within 12 months of the date of service. A claim for benefits filed after that date may be declined or reduced unless:

1. It is not reasonably possible to submit the claim within 12 months of the date of service; or

2. The claimant is not legally capable of submitting the claim within 12 months of the date of service.

C. Claim for Benefits Procedure

There are different kinds of claim for benefits and each one has a specific timetable for approval, payment, request for further information, or denial. The period of time begins on the date the claim is filed. The following is a summary of the maximum response times allowed for each type of claim.

Pre-Service Urgent Care Claims

Notice to claimant of:	
Insufficient information on the claim for benefits	24 hours
Extension for claimant to provide required information	48 hours
Benefit determination	72 hours

Pre-Service Non-Urgent Care Claims

Notice to claimant of:	
Insufficient information on the claim for benefits	5 calendar days
Extension for claimant to provide required information	45 calendar days
Benefit determination	15 calendar days

Post-Service Claims

Notice to claimant of:	
Benefit determination (all required information received)	30 calendar days
Extension for claimant to provide required information	45 calendar days
Benefit determination (requested information provided)	15 calendar days

D. Notice to Claimant of *Adverse Benefit Determination*

The *claims processor* shall provide written or electronic notice of any *adverse benefit determination*. The notice will state the following:

1. The specific reason(s) for the adverse determination.

2. Reference to the specific Plan provisions on which the determination was based.

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

4. A description of the Plan's appeal procedures, including, if applicable, a statement of the claimant's right to bring a civil action under section 502 of *ERISA*.

5. A statement that upon request, the claimant is entitled to receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

6. A statement that other voluntary dispute resolution options are available, such as

mediation.

If the *adverse benefit determination* was based on an internal guideline, protocol, or other similar criterion, the specific guideline, protocol, or criterion will be provided. If this is not practical, a statement will be included that such a guideline, protocol, or criterion was relied upon in making the *adverse benefit determination*, and a copy will be provided free of charge to the claimant upon request.

If the *adverse benefit determination* is based on the *medical necessity*, *experimental*, or *investigational* exclusions of the Plan, an explanation of the clinical judgment for the determination will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

E. First Level Internal Appeal

You or your authorized representative may appeal an *adverse benefit determination*. Upon request, the *claims processor* will complete a full and fair review. When a claimant receives an *adverse benefit determination* for a claim, the claimant has 180 days following receipt of the notification to appeal the decision. Otherwise, the initial *adverse benefit determination* shall be the final decision of the Plan.

When a claimant receives an *adverse benefit determination* for a pre-service claim, a grievance can be filed with the *claims processor* orally or in writing. A grievance for a post-service claim must be submitted in writing.

This Plan provides for two levels of internal appeals. If the *adverse benefit determination* is partially or fully upheld, a claimant may appeal the initial appeal decision. If the benefit determination is partially or fully upheld upon second appeal, a claimant may appeal under the external review provisions of this Plan. The following is a summary of the maximum response times allowed for each type of claim appeal.

Pre-Service Urgent Care Claims

Initial internal appeal	24 hours for phone response (written response within 3 business days of phone response)
Second internal appeal	24 hours for phone response (written response within 3 business days of phone response)

Pre-Service Non-Urgent Care Claims

Initial internal appeal	15 calendar days
Second internal appeal	15 calendar days

Post-Service Claims

Initial internal appeal	30 calendar days
Second internal appeal	30 calendar days

The period of time within which the Plan must make a benefit determination for an appeal begins at the time an appeal is filed in accordance with the procedures of the Plan. During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any appeal is pending.

For any appeal, a claimant may submit written comments, documents, records, and other information related to the claim for benefits. If the claimant requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

A document, record, or other information shall be considered relevant to a claim for benefits if it:

1. Was relied upon in making the benefit determination;

2. Was submitted, considered, or generated in the course of making the benefit determination;

3. Demonstrated compliance with the administrative processes and safeguards designed to ensure that benefit determinations are made in accordance with Plan documents, and that Plan provisions have been applied consistently with respect to all claimants; or

4. Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

Any review shall take into account all information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial *adverse benefit determination*, and will be conducted by a Plan representative who is neither the individual who made the adverse determination nor a subordinate of that individual. The *claims processor* may hold a hearing of all parties involved, if the *claims processor* deems such hearing to be necessary.

If the determination was based on a medical judgment, including determinations with regard to whether a particular service or supply is *experimental*, *investigational*, or not *medically necessary* or appropriate, the representative of the Plan will consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the applicable field of medicine. Additionally, the Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination.

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

F. Second Level External Review

You may file a request for an external review by an independent review organization (IRO) no later than four months following the date you receive a notice of an *adverse benefit determination* or final internal *adverse benefit determination.*

Within five business days following receipt of your external review request, the *claims processor* must complete a preliminary review of your request. If the appeal is granted, the *claims processor* must assign an IRO to conduct the external review and will submit all information to the IRO.

Within one business day following the preliminary review, the *claims processor* must issue a written notification to you indicating the status of your request. If additional information is required, the written notification will include a description of the material or information necessary for you to perfect your external review request within the four-month filing period.

Upon receipt of the material or information requested, the *claims processor* will review the information and forward it to the IRO within one business day. If, upon receipt of this information, the *claims processor* reverses the internal *adverse benefit determination*, the *claims processor* must send written notification to the IRO and to you within one business day after making such a decision. The assigned IRO must terminate the external review upon receipt of the notice from the *claims processor.*

For any other appeal not reversed by the *claims processor*, the IRO must provide written notice of the final external review decision within 45 days after receipt of the request for external review. The IRO must deliver this final notice to you and the *claims processor.* The decision of the IRO shall be the final decision of the Plan.

The IRO will conduct their review and will not be bound by any decisions or conclusions previously reached by the *claims processor.*

G. Second Level Expedited External Review

The external review process will be expedited if:

1. You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or

2. The internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service which you received on an emergency basis,

but have not yet been discharged from a facility.

Upon receipt of your request for expedited external review, the *claims processor* must immediately verify eligibility for external review, issue a notification in writing to you, and assign an IRO. The IRO is required to provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision within 48 hours after the date of providing that notice to you and the *claims processor*.

H. Eligibility Claims

This Section I details the procedure for claims that pertain to an individual's eligibility for coverage under the Plan. Eligibility claims also include requests to change an election to participate during the year.

Important

If a person believes he or she is being wrongfully denied the right to participate in the Plan, the person must file a claim with the Resident Benefits Manager. No person who claims to be entitled to rights or benefits will be entitled to file suit in any court of law until he or she exhausts the Plan's administrative procedures for deciding claims.

Definition of "Claim"

An eligibility "claim" is any request for coverage under the Plan that is made in accordance with these claims procedures. A communication that is not made in accordance with these procedures will not be treated as a claim under these procedures.

How to File an Eligibility Claim

To initiate an eligibility claim, you must file a written request with the Resident Benefits Manager. A mere inquiry, verbally or in any other manner, is not a valid claim and, as such, does not initiate the ERISA claims and appeals procedures described below. Your claim must describe the coverage for which you are applying and the reasons for the request. You will also be required to submit relevant documentation. If you fail to provide sufficient information, the Resident Benefit Manager will provide you with a notice explaining what is needed and when it must be provided.

When Your Claim Will be Decided

The Resident Benefits Manager will notify you of its decision within 90 days of the date it receives your written claim. In special circumstances, this period may be extended to 180 days. The Resident Benefits Manager will notify you before the 90-day period expires if additional time is needed.

How Notice Will be Provided

You will be notified in writing of the decision on your claim. If your claim is partly or entirely denied, the written notice will contain the specific reason for the denial, the plan provisions on which the denial is based, any additional material or information you may need to submit to support your claim, and the Plan's appeal procedures.

Your Right to an Appeal

You have the right to appeal an eligibility claim denial. Your appeal must be filed within 60 days from the date you receive written notice of your denied claim.

Important

Before you can challenge a denial in court, you must exhaust the Plan's appeal process. If you fail to appeal an adverse determination within the 60-day period, you will forever lose the right to file suit.

All appeals must be filed in writing with the Resident Benefits Manager.

When Your Appeal Will be Decided

The Resident Benefits Manager will notify you of its decision within 60 days of the date it receives your written claim. In special circumstances, this period may be extended to 120 days. The Resident Benefits Manager will notify you before the 60-day period expires if additional time is needed.

You will be notified in writing of the decision on your claim. If your claim is partly or entirely denied, the written notice will contain the specific reason for the denial, the plan provisions on which the denial is based, any additional material or information you may need to submit to support your claim, and the Plan's appeal procedures.

Appeal decisions will not be reviewed and are considered final unless new circumstances arise or new facts are discovered that could not have been presented before the final determination was rendered. You have the right to bring a civil action.

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

A. Definitions

For purposes of this section, the terms listed below shall be defined as follows:

1. **COBRA**. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2. **Code**. The Internal Revenue Code of 1986, as amended.

3. **Continuation Coverage.** The Plan coverage elected by a qualified beneficiary under *COBRA*.

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

5. **Qualified Beneficiary.**

   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*.

6. **Qualifying Event.** 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.

B. Right to Elect Continuation Coverage

If a qualified beneficiary loses coverage under the Plan due to a qualifying event, he may elect to continue coverage under the Plan in accordance with *COBRA* upon payment of the monthly contribution specified by the *COBRA administrator* 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 (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 loss of eligibility, the qualified beneficiary must notify the *COBRA administrator* 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 *COBRA 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 *COBRA administrator* 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 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, or dependent children who have become ineligible for coverage may continue coverage under the Plan for up to thirty-six (36) months from the date of the qualifying event.

E. Total Disability

1. 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) may continue coverage (including coverage for dependents who were covered under the continuation coverage). Coverage may continue for a total of twenty-nine (29) months as long as the qualified beneficiary notifies the *employer* that he was disabled as of the date of the qualifying event:

    a. Prior to the end of eighteen (18) months of continuation coverage; and

    b. Within sixty (60) days of the determination of total disability under the Act.

2. The *COBRA administrator* 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, the qualified beneficiary shall notify the *COBRA administrator* of this determination within thirty (30) days. 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 *COBRA administrator* 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.

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 *plan sponsor* 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 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 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-pay features for the year will be carried forward into the continuation coverage elected for that year.

Similarly, If continuation coverage under the Plan is elected by a qualified beneficiary under *COBRA*, expenses already credited to the Plan's applicable maximum for the year will be carried forward into the continuation coverage elected for that year.

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.

    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 *COBRA administrator*, 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 *COBRA administrator* 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

The Plan uses and discloses health information about you and any covered dependents only as needed to administer these programs.

The Plan's group health programs will comply with the applicable health information privacy requirements of federal rules issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's "Notice of Privacy Practices." If you are an Employee and you are covered under any of the Plan's group health programs, you should have received a copy of the Plan's Notice of Privacy Practices (if you did not previously receive one). In addition, a copy of this notice is always available upon request.

Please contact the *plan administrator* if you would like to request a copy of the Notice of Privacy Practices, or if you have questions about the Plan's privacy policies.

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 and Covered Dental Expenses.

Adverse Benefit Determination

Any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage;
- A termination of benefits; or
- A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

Affiliated Hospital

Buffalo General Medical Center
Oishei Children's Hospital
Millard Fillmore Hospital – Suburban
Erie County Medical Center
Roswell Park Comprehensive Cancer Center
Olean General Hospital
Sisters of Charity Hospital
Mercy Hospital of Buffalo

Alternate Procedure

The most cost effective treatment of a dental condition which will provide a professionally acceptable result as determined by national standards of dental practice. Consideration is given to the current clinical oral condition based upon the diagnostic material submitted by the *dentist*.

Alternate Recipient

Any child of a participant who is recognized under a medical child support order as having a right to enrollment under this Plan as the participant's eligible dependent. For purposes of the benefits provided under this Plan, an *alternate recipient* shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements under *ERISA*, an *alternate recipient* shall have the same status as a participant.

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.

Approved Clinical Trial

A clinical trial that is conducted in relation to treatment of cancer or other life-threatening disease or condition that is:

- A federally funded trial approved or funded by one or more of the following:
    - The National Institutes of Health (NIH).
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare and Medicaid Services.
    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veteran Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
    - The Department of Defense, the Department of Energy, or the Department of Veteran Affairs if 1) the study has been approved through a system of peer review determined to be comparable to the system used by NIH and 2) assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review.
- A study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- A study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Benefit Year

The 12-month period beginning July 1 and ending June 30. All annual deductibles and benefit maximums accumulate during the *benefit year*.

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.

Claims processor

BlueCross BlueShield of Western New York
257 West Genesee Street
P.O. Box 80
Buffalo, NY 14240

Cosmetic Surgery

Any expenses incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an *injury*.

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

Durable Medical Equipment

Equipment and/or supplies ordered by a *health care provider* for everyday or extended use which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose; and
- Generally is not useful to a person in the absence of an *illness* or *injury*.

Electronic Protected Health Information

Protected health information that is transmitted or maintained in any electronic media.

Emergency

A situation or medical condition with symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, would reasonably expect the absence of immediate medical attention to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

An *emergency* includes, but is not limited to, suspected heart attack or severe chest pain, actual or suspected poisoning, unconsciousness, hemorrhage, acute appendicitis, heat exhaustion, convulsion, or such other acute medical conditions as determined to be *medical emergencies* by the *claims processor*.

Employer

University Medical Resident Services, P.C. and University Dental Resident Services, P.C.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

Experimental/Investigational

Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the *illness*, *injury*, or condition at issue.

Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered *experimental* or investigational in nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered *experimental* or investigational in nature.

Experimental/investigational items and services are not covered under this Plan unless identified as a covered service elsewhere in this Plan.

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, health care providers* or *dentists*.

FMLA

The Family and Medical Leave Act of 1993, as amended.

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.

GINA

The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of *genetic information*.

Health Care Provider

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

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended.

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 or the prior plan sponsored by University Medical Resident Services, P.C. and University Dental Resident Services, P.C. prior to the restatement date of July 1, 2018.

Maintenance Care

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

Medical Director

A *physician*, compensated by the *claims processor*, who provides health care utilization advise to the *claims processor*. In addition, the Medical Director:

- Monitors and evaluates health care utilization including quality of care and safety issues, adherence to clinical guidelines, protocols, etc.

- Provides guidance of case management, utilization management, medical management, treatment plans, quality and safety related to appropriate utilization and review of an *adverse benefit determination*.

- Establishes best practices and documents appropriate guidelines.

- Reviews and evaluates new applications of existing technology and new medical procedures for medical policy.

Medically Necessary (Medical Necessity)

Medically necessary, *medical necessity*, and similar language refers to health care services ordered by a *physician* exercising prudent clinical judgment provided to a participant for the purposes of evaluation, diagnosis or treatment of that patient's *illness* or *injury*. *Medically necessary* services must be clinically appropriate in terms of type, frequency, extent, site, and duration for the diagnosis or treatment of the patient's *illness* or *injury*. Further, to be considered *medically necessary*, services must be no more costly than alternative interventions, and are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of the patient's *illness* or *injury* without adversely affecting the patient's medical condition.

A *medically necessary* service must meet all of the following criteria:

- It must not be maintenance therapy or maintenance treatment;
- Its purpose must be to restore the patient's health;
- It must not be primarily custodial in nature; and
- It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of *medical necessity*.

Merely because a *health care provider* recommends, approves, or orders certain care does not mean that it is *medically necessary*. The determination of whether a service, supply, or treatment is or is not *medically necessary* may include findings of the American Medical Association and the *claims processor's* own medical advisors.

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 designated by the *employer* prior to each *plan year* during which employees may elect benefits available under this *Plan*. Coverage elected during the *open enrollment period* will be effective the first day of the subsequent *plan year*.

Oral Surgery

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

Other Plan

Plans including, but not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering a claimant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Workers' compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Outpatient

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

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*, University Medical Resident Services, P.C. and University Dental Resident Services, P.C., is a named fiduciary of the Plan, and exercises 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, except to the extent this authority is delegated to the *claims processor*.

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, except to the extent such authority is delegated to the *claims processor*.

Plan Sponsor

University Medical Resident Services, P.C. and University Dental Resident Services, P.C.

Plan Year

The 12-month period for University Medical Resident Services, P.C. and University Dental Resident Services, P.C., beginning July 1 and ending June 30.

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-Treatment Review

A written proposed course of treatment estimated to be over $300 must be submitted by your *dentist* for review prior to the actual performance of services. Evaluation of the course of treatment is subject to *alternate procedure* and does not guarantee payment of the benefits when the actual services are performed.

Professional Components

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

Protected Health Information

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*. Personal health information includes information of persons living or deceased. The following components of a *member's* information also are considered personal 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.

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.

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.

Second/Third 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.

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* is an employee or dependent who is entitled to and who requests special enrollment:

1. 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;

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

3. within sixty (60) days of losing other health coverage through Medicaid or CHIP.

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. Surgery includes closed reduction of fractures, dislocation of bones, endoscopic procedures, and any incision or puncture of the skin or other tissue except for inoculation, vaccination, collection of blood, drug administration or injection.

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.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994.

Usual and Customary Charge

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 other *physicians*, *practitioners* or *dentists*.

Waiting Period

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

Year

See *Benefit Year*.

ARTICLE XIV -- GENERAL INFORMATION

Name and Address of the Plan sponsor

University Medical Resident Services, P.C. and University Dental Resident Services, P.C.
University at Buffalo, Office of Graduate Medical Education
Jacobs School of Medicine and Biomedical Sciences
955 Main Street, Suite 7230
Buffalo, NY 14203

Name and Address of the Plan Administrator

University Medical Resident Services, P.C. and University Dental Resident Services, P.C.
University at Buffalo, Office of Graduate Medical Education
Jacobs School of Medicine and Biomedical Sciences
955 Main Street, Suite 7230
Buffalo, NY 14203

The *plan administrator* is responsible for the overall management and administration of the Plan. In carrying out its functions, the *plan administrator* has the authority and discretion to construe the terms of the Plan and to determine all questions arising in connection with the administration, interpretation and application of the Plan. The *plan administrator* may delegate its duties to others. Any delegation of duties carries with it any authority (including discretionary authority) conferred upon the *plan administrator* by the terms of the Plan. The decisions of the *plan administrator* (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, interpretations, and disputed issues of fact) will be final and binding on all parties.

Name and Address of the Agent for Service of Legal Process

University Medical Resident Services, P.C. and University Dental Resident Services, P.C.
University at Buffalo, Office of Graduate Medical Education
Jacobs School of Medicine and Biomedical Sciences
955 Main Street, Suite 7230
Buffalo, NY 14203

Legal Actions

The *plan sponsor* is the agent for service of legal process upon the Plan. This Plan will be interpreted according to the laws of the State of New York, without reference to its choice of law provisions, to the extent not preempted by federal law. In any dispute involving the Plan, exclusive jurisdiction and venue will be in the state or federal courts located in Erie County, New York.

Please take particular note of the following:

- All disputes concerning the Plan must be adjudicated under the Plan's disputed claim and appeal procedures. See **Article X**. A person claiming entitlement to coverage or benefits

may not file legal action unless the claim or dispute is adjudicated using the Plan's required claims and appeal procedure. **Failure to exhaust the Plan's claims and appeal procedures may result in a permanent loss of benefits.**

- Legal actions involving the Plan (e.g., legal actions seeking entitlement to Plan benefits) must be commenced within 6 months following the date the *claims processor* renders a final written decision regarding a claim.

- If a claimant fails to meet the deadline for filing a legal action (referred to as a "statute of limitations"), the claimant will permanently forfeit the right to file a lawsuit challenging the decision of the *plan administrator* or *claims processor*.

Claims processor

BlueCross BlueShield of Western New York
P.O. Box 80
Buffalo, NY 14240

Internal Revenue Service and Plan Identification Number

University Medical Resident Services, P.C.: The corporate tax identification number assigned by the Internal Revenue Service is 16-1397017. The plan number is 501.

University Dental Resident Services, P.C.: The corporate tax identification number assigned by the Internal Revenue Service is 16-1397019. The plan number is 501.

Plan Year

The 12-month period for University Medical Resident Services, P.C. and University Dental Resident Services, P.C., beginning July 1 and ending June 30.

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 Status

Non-Grandfathered.

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

As a participant in the University Medical Resident Services, P.C. and University Dental Resident Services, P.C. 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, and you must exercise this right or forfeit the benefit or right to which you claim entitlement, as well as the right to file suit.

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.

Notice of Nondiscrimination

BlueCross BlueShield of Western New York

BlueCross BlueShield of Western New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BlueCross BlueShield of Western New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BlueCross BlueShield of Western New York:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the customer service number on the back of your ID card or contact the Director, Corporate Compliance and Privacy Officer.

If you believe that BlueCross BlueShield of Western New York has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Director, Corporate Compliance and Privacy Officer, 257 West Genesee Street, Buffalo, NY 14202, 1-800-798-1453, (716) 887-6056 (fax), complaint.compliance@bcbswny.com. You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *httos://ocrportal hhs.gov/ocr/oortal/lobby.isf.* or by mail *or* phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at *http://Www .h hs.gov/ocr/office/fi /elindex.html*.

Notice of Nondiscrimination

BlueCross BlueShield of Western New York

For assistance in English, call customer service at the number listed on your ID card.

Para obtener asistencia en espaiiol, llame al servicio de atenci6n al cliente al numero que aparece en su tarjeta de Identi ficaci6n.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

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한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Per assistenza in Italiano chiamateii numero del servizio clienti riportato nella vostra scheda identi ficativa.

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বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

Aby uzyskac pomoc w j zyku polskim, nalezy zadzwonic do dzi alu obslugi klienta pod numer podany na identy fikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en fr an ais, composez le numero de telephone du service a l a clientele figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tu long sa Tagalog, tumawag sa num ero ng serbisyo sa cu stomer na nasa inyong ID card.

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Per ndihmi! ni! gjuhi!n shqipe, merrni ne telefon shi!rbimin klientor ni! numrin e renditur ni! karti!n tuaj ti! identitetit.