SUMMARY PLAN DESCRIPTION
OF THE DENTAL BENEFITS
UNDER THE
HERKIMER COUNTY HEALTH PLAN

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January 1, 2011
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INTRODUCTION

Herkimer County (the "Employer") established the Herkimer County Health Plan (the "Plan") effective January 1, 1950 to provide health benefits for its eligible employees. This Summary Plan Description ("SPD") presents a brief description of the Plan. It is not meant to interpret, extend, or change the official Plan documents. If there is any conflict between this SPD and the Plan documents, the Plan documents will govern your rights to benefits. Copies of the Plan documents are available for inspection in the Personnel Office, Herkimer County, 109 Mary Street, Suite 1304, Herkimer, New York, 13350, during regular business hours.

The information in this SPD may be modified by a "Summary of Material Modification" ("SMM"). Check to see if there are any SMMs attached when you refer to this SPD.

Grandfathered Plan Status

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at Herkimer County, 109 Mary Street, Suite 1304, Herkimer, New York 13350

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.
IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name: Herkimer County Health Plan

Plan Number: 510

Plan Type: Welfare Plan providing dental benefits

Plan Year: The Plan Year begins on January 1 and ends on December 31.

Employer and Plan Sponsor:
Herkimer County
109 Mary Street
Suite 1304
Herkimer, New York 13350
315-867-1115

Employer Identification Number: 15-6000456

Plan Administrator:
Herkimer County
109 Mary Street
Suite 1304
Herkimer, New York 13350
315-867-1115
Summary Plan Description
of the Dental Benefits under the
Herkimer County Health Plan

Type of Plan Administration:
The Plan is self-funded by the Employer, which means that all benefits are paid from the general assets of the Employer. EBS-RMSCO, Inc., 115 Continuum Drive, Liverpool, NY 13088, processes benefit claims and pays benefits for the Employer, but is not the Plan Administrator or the insurer for the Plan. The Employer is responsible for determining the types of benefits available under the Plan, deciding requirements for eligibility to participate in the Plan, and setting participants' cost for coverage. The Personnel Office is the primary source for information about these aspects of the Plan.

Plan Agent for Service of Legal Process:
Herkimer County
109 Mary Street
Suite 1304
Herkimer, New York 13350
1. **Who is eligible to become a participant in the Plan?**

An employee of the Employer who works 20 or more hours per week is eligible to become a participant with the exception of the Sheriff's Department. Under the Deputy Sheriff's contract: "Part time Sworn Personnel and Part Time Cooks are entitled to purchase dental insurance by paying 100% of the cost by the first of each month". Under the United Public Service Employees Union (Highway workers): "Seasonal employees are entitled to purchase dental insurance by paying 100% of the cost by the first of each month".

A person providing services to the Employer through a temporary agency or employee leasing organization, or as an independent contractor, is not eligible to participate even if that person is later classified as an employee of the Employer for employment tax, unemployment insurance, or other purpose, by a government agency or a court.

2. **How do I become a participant in the Plan?**

You must complete an enrollment form and return it to the Personnel Office no later than:

- within 30 days after you satisfy the requirements for eligibility, or
- before the end of any open enrollment period announced by the Employer (assuming you still satisfy the eligibility requirements).

You must indicate your choice for the level of coverage (single, or family coverage) on the enrollment form. By returning a completed enrollment form, you agree to pay your portion of the cost for coverage through payroll deductions.

If you do not enroll during the periods described above, special enrollment rules may allow you to enroll at other times.

3. **When do the special enrollment rules apply?**

Generally, these special rules apply in the following situations:

- You initially declined Plan coverage because you had other dental care coverage, but you later lose that other coverage through no fault of your own. You can enroll yourself, your spouse and your eligible dependents.
within thirty (30) days after losing the other dental care coverage. Note, for this special enrollment rule to apply, you may be required to provide in writing the reason you declined Plan coverage at the time you decline it.

- You initially declined Plan coverage because you had other dental care coverage from another employer, but that employer stops contributing toward the cost of that other coverage. You can enroll yourself, your spouse and any eligible dependent within thirty (30) days after that employer stops contributing toward the cost of the other coverage. Note, for this special enrollment rule to apply, you may be required to provide in writing the reason you declined Plan coverage at the time you decline it.

- You declined Plan coverage and you later acquire a new spouse or a new eligible dependent (through birth or adoption of a child), and you wish to cover that person. You can enroll yourself, your spouse and your eligible dependents within the thirty (30) day period after the marriage, birth, adoption or placement for adoption.

- If you, your spouse or eligible dependent lose eligibility for Medicaid coverage or coverage under a State Children’s Health Insurance Program on or after April 1, 2009. You can enroll yourself, your spouse or your eligible dependent within the sixty (60) day period following the loss of that coverage.

- If you, your spouse or eligible dependent become eligible to participate in a premium assistance program under Medicaid or a State Children’s Health Insurance Program on or after April 1, 2009. You can enroll yourself, your spouse or your eligible dependent within the sixty (60) day period following that eligibility determination.

4. When does my Plan coverage begin?

Your coverage will begin on:

- the 1st of the month following 60 days of employment provided you satisfy the requirements for eligibility and you complete and file your enrollment form within 30 days of satisfying the requirements.
the first day of the plan year after the end of an open enrollment period if you complete and file your enrollment form during the open enrollment period

if a special enrollment rule applies (see Question & Answer 3), the date you complete and file your enrollment form

Except when a special enrollment rule applies (see Question & Answer 3), Plan coverage for an eligible dependent will begin on:

the date your coverage begins if you enrolled the dependent for coverage

the date you acquire a new eligible dependent, provided you enroll the dependent within thirty (30) days of acquiring the new dependent (through marriage, or birth or adoption of a child) if you have enrolled for family coverage.

Your eligible dependents are:

• Your spouse

• an unmarried child under age 19 who is not on active military duty in the armed services of any country

• an unmarried child under age 25 who is a full-time college student and is financially dependent on you

• an unmarried child who became physically or mentally disabled (provided such condition occurred before the child reached the age at which his coverage under the Plan would otherwise terminate).

Your child is:

• a newborn, natural child, or a child placed with you for adoption;

• a stepchild who receives more than one-half of his or her support from you; or
any other child for whom you have legal guardianship or court-ordered custody, provided that the child receives more than one-half of his or her support from you.

If both you and your spouse are employees and participating in the Plan, neither of you are treated as the dependent of the other, and your children will be considered dependents of one, but not both, of you.

5. How much must I pay for coverage?

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<th>Division #4 (CSEA)</th>
<th>Division #3 (Highway)</th>
<th>Division #2 (Exempt)</th>
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<tr>
<td>Single $3.84</td>
<td>Single $3.15</td>
<td>Single $5.30</td>
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<tr>
<td>Family $13.47</td>
<td>Family $11.05</td>
<td>Family $17.63</td>
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At this time, Herkimer County pays 100% of the cost for eligible employees, other than those employees who pay the full cost as described in Question and Answer 1.

The schedules of the current cost are attached. If there are ordinary increases or decreases in your share of the cost, your payroll deductions will automatically be adjusted to reflect any change in your cost. The Employer will provide participants with advance written notice of any changes to their cost.

6. When can I change my coverage?

In general, once you have enrolled (or decided not to enroll) in the Plan, you cannot change your decision until an open enrollment period, which is usually just before the next Plan Year. However, you may be able to change your enrollment decision, and/or your type or level of coverage, if any event occurs that entitles you to special enrollment rights (see Question & Answer 3).

You may also be able to make a change if any of the following occurs during a Plan Year:

- a change in dental coverage available through a spouse's employment
- a change in legal marital status (e.g., through marriage, divorce, legal separation, annulment, or death of spouse)
a change in your employment status, or the employment status of your spouse or dependent

your residence changes to a place outside the area for the type of coverage you chose

a change in your work schedule or the work schedule of your spouse or dependent (e.g., an unpaid leave of absence, switch between full-time and part-time, or a strike or lockout)

the coverage you chose is eliminated or is significantly curtailed

the cost of your coverage you chose significantly increases.

Contact the Personnel Office immediately if any of these events occurs and you want to change your enrollment decision and/or your type or level of coverage. Even if you can make the change you desire, you will have a limited period of time after the event (30 days) to make it.

7. What benefits are available if I am a participant in the Plan?

The benefits available under the Plan are described in the Appendix at the end of this SPD.

8. When does my coverage end?

Unless you are eligible for and elect COBRA coverage (see Question & Answer 16 for an explanation of this coverage), your coverage under the Plan will end on if terminated on the 1st-15th of the month, coverage ends at the end of the month of termination if terminated on the 16th-end of the month at the end of the following month in which your employment terminates or you no longer satisfy the eligibility requirements to participate in the Plan. Your coverage will also end if you do not pay your share of the premiums.

9. When does coverage for my spouse or dependent end?

Unless your spouse or dependent is eligible for and elects COBRA coverage (see Question & Answer 16 for an explanation of this coverage), his or her coverage under the Plan will end on:
• the date your Plan coverage ends

• in the case of your spouse, upon divorce

• in the case of a dependent, when he or she no longer qualifies as an eligible dependent.

10. What happens when I retire?

Retirement is treated as the termination of your employment and your coverage under the Plan will end as described above (See Question 8 "When does my coverage end?").

11. What happens if the Plan pays a benefit that it should not have paid?

If payments are made by the Plan that exceed the Plan’s benefit limits, or any other Plan rule or provision, the excess amount may be recovered from the person who received the payments, the person for whom the payments were made, or from any insurance company or other party that should pay the expense for which the excess payment was made. The Plan Administrator can also decrease (up to the amount of the excess payment) any future benefits otherwise payable under the Plan to the participant who benefited from the excess payment.

12. What happens if the Plan pays a benefit for me or my dependent relating to an injury, sickness or condition caused by another person?

In that case, the Plan is subrogated to any right the participant and his dependents (or their legal representative, heirs or beneficiaries) may have against any third party that caused the injury, sickness or condition. The participant and his dependents (and their legal representative, heirs and beneficiaries) may not act to prejudice this right of subrogation, and must execute and deliver documents and do whatever else is necessary to secure the Plan’s right of subrogation (including the right to sue the third party). The Plan Administrator may require the participant and his dependents (and their legal representative, heirs or beneficiaries) to sign an agreement acknowledging these subrogation rights as a condition to receiving payment from the Plan. However, the Plan’s subrogation rights will not be affected if the Plan Administrator does not require such an agreement.
These subrogation rights are not diminished or otherwise affected if the total recovery obtained by the participant or dependent is less than the amount necessary to make him whole for all of the expenses and other damages related to the injury, sickness or condition.

13. **Who decides what benefits are available under the Plan and which employees are eligible to participate?**

The Plan Administrator has the power and discretion to: change the terms of the Plan (including rules for eligibility to participate); establish, increase, decrease or eliminate specific Plan benefits; and administer the Plan in all of its details, including the authority to: (i) decide issues of fact relevant to the eligibility of any person to receive benefits, or the amount or time of payment of benefits; (ii) interpret the terms of the Plan; (iii) supply any omission, interpret any ambiguous or uncertain provision of the Plan, and reconcile any inconsistency that may appear in the Plan.

14. **Can the Employer ever amend or terminate the Plan?**

Yes. The Employer maintains the Plan on a voluntary basis and has the right to amend or terminate the Plan, and terminate any coverage provided under the Plan, at any time with respect to any individual, group, or class of employees, including retirees and employees eligible to retire and elect retiree coverage. Employees and retirees never have a vested right to coverage.

15. **What if I have questions about coverage or benefits, or want to make a claim for benefits?**

If you have questions about eligibility under the Plan or the cost of coverage, you should contact the Personnel Office. If you have questions about specific benefits, you should contact:

EBS-RMSCO, Inc.
115 Continuum Drive
Liverpool, NY 13088
Tel. No. (800) 803 5773

Claims for benefits should also be submitted to EBS-RMSCO, Inc.
The claim procedures are different for "concurrent claims," "pre-service claims," "post-service claims," and "urgent claims." A concurrent claim is a request for an extension of health treatment (i.e., treatment provided over a period of time or a number of treatments). A pre-service claim is a claim requiring advance approval to receive all or part of the benefit. A post-service claim is any claim that is not a pre-service claim. An urgent claim is any claim for medical care or treatment that, if non-urgent claim procedures were followed, could seriously jeopardize the life or health of the patient or his ability to regain maximum function, or in the opinion of a physician with knowledge of the patient's medical condition would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested.

You may appoint someone to file a claim and act on your behalf; provided you give the Plan signed written notification of the appointment. In the case of an urgent claim, a health care professional with knowledge of your medical condition will be permitted to act as your representative.

Post-service claims must be filed within 90 days after the service or expense claimed was incurred. All claims must be filed on forms provided by EBS-RMSCO, Inc. and submitted by mail, except that urgent claims may be made orally and information may be transmitted by telephone 1-800-803-5773 or by facsimile 1-315-671-9809, provided that any necessary written forms are later completed and filed.

If you make a request for benefits that does not comply with the Plan's procedure for pre-service claims, you will be notified of the proper procedure within 24 hours if it involves an urgent pre-service claim, or within five days if it involves a non-urgent pre-service claim. (This notification may be oral, unless you request written notification.)

If a claimant fails to submit sufficient information for a determination on an urgent claim, he will be notified of the specific information necessary to complete the claim within 24 hours after the Plan receives the claim. He may then submit the additional information within 48 hours, and will be notified of the determination on his claim within 48 hours after the earlier of the receipt of the additional information or the end of the period the additional information could have been submitted.

A claimant will be notified of the determination on his claim within: 24 hours in the case of a concurrent claim involving urgent health care if the request is received at least 24 hours before the scheduled expiration of the treatments; 72 hours in the case of any other urgent claim (or earlier if possible); 15 days in the case of a non-urgent pre-service claim; or 30 days in the case of a post-service claim. However, if an extension to make a
determination on a non-urgent claim is necessary due to reasons beyond the Plan’s control, the time to make the determination may be extended for up to another 15 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected. Also, if the extension is necessary because additional information is needed from the claimant, the claimant will be given 45 days from the date he receives the notice to provide the information.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination; (iv) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (v) a description of the Plan’s review procedures and time limits; (vi) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act following an adverse determination upon review; (vii) if the Plan relied upon an internal rule, guideline, protocol or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and that a copy of the criterion is available free of charge upon request; (viii) if the determination was based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant’s medical circumstances), or a statement that such explanation will be provided free of charge upon request; and (ix) for urgent claims, a description of the expedited review procedure for such claims. This notice may be provided orally for an urgent claim, but will then be sent to the claimant in writing within three days after oral notification.

Within 180 days after receiving an adverse determination, a claimant may file a written appeal to EBS-RMSCO, Inc. Customer Service Division or to your Plan Administrator for a full and fair review of the claim and determination. He may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. For an urgent claim, the claimant may request, in writing or orally, an expedited review of the initial determination, and information may be transmitted by telephone 1-800-803-5773 or by facsimile 1-315-671-9809, provided that any necessary written forms are later completed and filed.

A reduction or termination of health treatment (other than by Plan amendment or termination) will be treated as an adverse determination, and the participant or beneficiary
will be notified sufficiently in advance to allow him to appeal before the reduction or termination occurs.

The review on appeal will take into account all documents, records and information submitted by the claimant, and will be conducted by an appropriate named fiduciary who did not make the initial determination and who is not a subordinate of the person who did. For a claim based on medical judgment (e.g., whether a treatment or drug is experimental, investigational, or medically necessary or appropriate), the person conducting the review will consult with a state licensed or certified independent health care professional with appropriate training and experience in the field who was not consulted in connection with the initial determination and is not a subordinate of any health care professional who was consulted.

The claimant will be notified of the determination on review within 72 hours after the Plan receives the request for review of an urgent claim (or earlier if possible), 30 days after the Plan receives a request for review of a non-urgent pre-service claim, or 60 days after the Plan receives a request for review of a post-service claim.

The notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) if the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request; (v) if the determination is based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; (iv) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act; and (v) the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

16. What additional rights does a participant have?

Federal law gives participants rights with regard to coverage and certain specific benefits. The following is a summary of those rights.
Health Insurance Portability and Accountability Act of 1996

You may be entitled to commence, continue, suspend and recommence participation in this Plan in accordance with your rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Information concerning your HIPAA rights is available from the Personnel Office, Herkimer County, 109 Mary Street, Suite 1304, Herkimer, New York, 13350, 315-867-1115.

Uniformed Services Employment and Reemployment Rights Act

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") also gives an employee who is absent from work due to service in the uniformed services (including active or reserve duty, whether voluntary or involuntary, and time off for training or instruction) the right to continuation coverage under the Plan if the employee is covered under the Plan when the period of military service begins, and certain other requirements are satisfied. For example, the period of military service generally cannot exceed five years, and the employee (or an appropriate officer) must give advance oral or written notice of the absence to the employee’s employer as early as is reasonable under the circumstances, unless notice is prevented by military necessity or is otherwise impossible or unreasonable under the circumstances.

An employee entitled to USERRA continuation coverage may elect continuation coverage (for him/herself and his/her covered dependents) for a period of up to 24 months. However, USERRA continuation coverage will terminate if the employee’s military service ends because of: (i) separation from service with a dishonorable or bad-conduct discharge; (ii) separation from service under certain less-than-honorable conditions; or (iii) for a commissioned officer, dismissal in connection with a court-martial or, in time of war, by the President, or dropping of the commissioned officer from the rolls as a result of an unauthorized absence for at least three months or as a result of a sentence imposed after a court-martial or a conviction in another court. USERRA continuation coverage will also terminate if the employee fails to report back to work or apply for reemployment within the time period required under USERRA after completion of military leave.

All election and premium payment procedures, rules and deadlines for USERRA continuation coverage under the Plan are the same as the COBRA continuation coverage election and premium payment procedures, rules and deadlines, except to the extent any of those procedures, rules or deadlines conflict with USERRA regulations (e.g., if
compliance with any particular procedure, rule or deadline is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

An employee also has the right to reinstatement in the Plan, without any exclusions or waiting periods due to the military leave, when he/she timely returns to work after a military leave, assuming he/she is otherwise eligible for Plan coverage. If the employee timely returns to work after a military leave before the maximum USERRA continuation coverage period but the employee is not reinstated in the Plan because he/she is not eligible for coverage at that time (for reasons unrelated to the military leave), then the employee has a right to continuation coverage for the entire 24 month USERRA continuation coverage period (or, if sooner, the date he/she is reinstated).

**Family and Medical Leave Act Leave**

If you are eligible for and take a leave of absence under the Family and Medical Leave Act ("FMLA Leave"), you may continue Plan coverage during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave and you pay the participant cost for Plan coverage during the FMLA Leave. Plan coverage will continue as if you were actively employed by the Employer until the earlier of the date (1) the FMLA Leave ends or, (2) you notify the Employer that you will not return to work. If you choose not to continue Plan coverage during an FMLA Leave, you may resume Plan coverage when you return to work, provided you return when the FMLA Leave expires and you are still an employee eligible to participate in the Plan (see Question and Answer 1), and any pre-existing condition exclusion rules under the Plan will be waived.

You are also eligible to elect COBRA coverage after the FMLA Leave if you:

- were covered under the Plan on the day before the FMLA Leave,
- do not return to work at the end of the FMLA Leave, and
- would otherwise lose coverage under the Plan.

You also may be able to elect COBRA coverage even if you choose not to continue regular Plan coverage during the FMLA Leave, or you stop paying your cost for Plan coverage during the FMLA Leave.
Information concerning your right to and obligations during a leave is available from the Personnel Office, Herkimer County, 109 Mary Street, Suite 1304, Herkimer, New York, 13350, 315-867-1115 or 315-867-1412.

HIPAA Privacy Rights

The Plan has responsibilities under Health Insurance Portability and Accountability Act ("HIPAA") regarding the use and disclosure of your protected health information ("PHI"). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (iii) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan’s privacy notice or more information about the Plan’s privacy practices, or you want to file a privacy violation complaint, please contact Mr. Steven Billings, Herkimer County, 109 Mary Street, Suite 1304, Herkimer, NY, 13350, phone 315-867-1115 or fax 315-867-1412.

COBRA Continuation Coverage

You may have a right under “COBRA” to continue to participate in the Plan after you would otherwise lose coverage under the Plan by continuing to make payments to the Plan, plus an administrative charge, on after-tax instead of a pre-tax basis. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family when they would otherwise lose your group health coverage. Below is a summary of COBRA continuation coverage, when it may become available, and what you need to do to protect the right to receive it.
What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a “dependent child.”
Summary Plan Description
of the Dental Benefits under the
Herkimer County Health Plan

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with the respect to Herkimer County, and that bankruptcy results in the loss of coverage of any retired employee coverage under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to Herkimer County or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Personnel Office, Herkimer County, 109 Mary Street, Suite 1304, Herkimer, NY, 13350. The notice must be in writing, and must contain your name and address, the name and address of any affected dependents, a description of the qualifying event, and the date of the qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or loss of a child's eligibility as a dependent child, COBRA continuation coverage lasts for up to total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled and you provide proper and timely notice of the SSA determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide this notice to: Personnel Office, Herkimer County, 109 Mary Street, Suite 1304, Herkimer, NY, 13350. The notice must be in writing, and must contain your name and address, the name and address of the disabled qualified beneficiary, and the date the disability was determined to have begun. You must also attach a copy of the SSA determination. You may be asked to provide additional documentation or information after you have submitted the notice.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage and you provide proper and timely notice of the second qualifying event, the spouse and dependent children in your family may be entitled to up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may
be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. You must provide this notice to: Personnel Office, Herkimer County, 109 Mary Street, Suite 1304, Herkimer, NY, 13350. The notice must be in writing, and must contain your name and address, the name and address of any affected dependents, a description of the second qualifying event, and the date of the second qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Information about the Plan and COBRA continuation coverage can be obtained from:

Herkimer County Health Plan
Personnel Office
Herkimer County
109 Mary Street
Suite 1304
Herkimer, New York 13350
315-867-1115

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is an order by a court for one parent to provide a child or children with health coverage. If the Plan receives a QMCSO for
your child or children, you will be contacted about the procedure for the QMCSO. Copies of the Plan’s QMCSO procedures are available, without charge, from the Plan Administrator.

Participating Provider Information

To access current Participating Provider Information free of charge, go to the following website:

   Excellus BlueCross BlueShield – www.excellusbcbs.com

Or you may contact the Personnel Office to request a copy of the Participating Provider List, free of charge.
Summary Plan Description
of the Dental Benefits under the
Herkimer County Health Plan

APPENDIX

BENEFITS
HERKIMER COUNTY
Employees

DENTAL PLAN 1
Option 1

Basic Dental Coverage:
- Simple extractions
- Fillings
- Prophylaxis (cleanings) – up to 2 cleanings per calendar year (including periodontal prophylaxis)
- Oral evaluations – up to 2 per calendar year
- X-rays – up to 1 full-mouth x-ray during any 36 consecutive months; up to 2 sets of bitewing x-rays per calendar year
- Fluoride applications – up to 2 topical applications per calendar year for covered dependents under age 19
- Repair of dentures
- Endodontics (root canals)
- Palliative emergency treatment

Additional Dental Coverage:
- Oral surgery
- Crowns (not part of a bridge or inserted over an implant)
- Inlays (not part of a bridge)
- Space maintainers – for covered dependents under 19 years of age/full-time students under 25 years of age
- Apicoectomy

Periodontic Coverage:
- Gingival curettage
- Gingivectomy and gingivoplasty
- Osseous surgery – 1 per quadrant per 24 months
- Mucogingivoplasty surgery

Orthodontic Coverage:
- For eligible dependents up to age 19
- Diagnosis, models and x-rays
- Comprehensive monthly treatment
- Subsequent retention of treatment
- $800 lifetime maximum payment

This document is intended to be a summary of the dental plan and is not a contract or guarantee of benefits.