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These are your

**University of Rochester**

**2015 COMPLEMENTARY CARE PLAN WITH MAJOR MEDICAL BENEFITS**

This Booklet explains your University of Rochester Complementary Care with major medical health benefits program (the "Program"). These benefits are sponsored and funded by the University of Rochester (the "Group"). Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield, Rochester Region ("Excellus BlueCross BlueShield"), administers claims for benefits under the Program on behalf of the Group and does not insure your benefits. Excellus BlueCross BlueShield provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims. Excellus BlueCross BlueShield is a nonprofit independent licensee of the BlueCross BlueShield Association. You should keep this Booklet with your other important papers so that it is available for your future reference.

**READ THIS ENTIRE BOOKLET CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE PROGRAM. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS BOOKLET.**

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## SECTION ONE - DEFINITIONS

### 1. Definitions.

- A. **Active Treatment.** Treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the Commissioner of Mental Health.
- B. **Allowable Expense.** “Allowable Expense” means the maximum amount payable for covered services under this Benefit Plan, before any applicable Deductible and Coinsurance amounts are subtracted. The Allowable Expense is determined as follows:
- (1) **Facility Services**
- (a) The Allowable Expense for covered services received from an In-Network Facility is the amount set by state or federal law. In the absence of state or federal law, the Allowable Expense for an In-Network Facility will be the amount the Claims Administrator has negotiated with the In-Network Facility or the amount approved by another Blue Cross and Blue Shield Plan. However, when the In-Network Facility’s charge is less than the amount that the Claims Administrator has negotiated with the In-Network Facility, your Deductible or Coinsurance amount will be based on the In-Network Facility’s charge.
- (b) The Allowable Expense for an Out-of-Network Facility (other than an Out-of-Network Facility providing services for an Emergency Condition) will be the lowest of:
- (i) The amount the Claims Administrator (or a contractor, acting on the Claims Administrator’s behalf) has negotiated with the Out-of-Network Facility;
- (ii) The average amount the Claims Administrator has negotiated with In-Network Facilities of the same type as the Out-of-Network Facility;
- (iii) The amount provided to the Claims Administrator by another Blue Cross and Blue Shield Plan; or
- (iii) The Facility’s charge.

- (2) **Professional Provider or Provider of Additional Health Services**
- (a) The Allowable Expense for covered services performed by an In-Network Professional Provider or an In-Network Provider of Additional Health Services will be the lower of:
    - (i) The amount listed on the Claims Administrator's fee schedule or, if outside the Service Area, the amount provided to the Claims Administrator by another Blue Cross and Blue Shield Plan; or
    - (ii) The Provider's charge.
  - (b) The Allowable Expense for services of an Out-of-Network Professional Provider and an Out-of-Network Provider of Additional Health Services (hereinafter collectively referred to as an Out-of-Network Service Provider) *inside* the Service Area, other than an Out-of-Network Service Provider rendering services inside the Service Area for an Emergency Condition, will be the lowest of:
    - (i) The amount listed on the Claims Administrator's fee schedule;
    - (ii) The amount the Claims Administrator (or a contractor, acting on the Claims Administrator's behalf) has negotiated with the Out-of-Network Service Provider; or
    - (iii) The Out-of-Network Service Provider's charge.
  - (c) The Allowable Expense for services of an Out-of-Network Service Provider (other than an Out-of-Network Service Provider rendering services for an Emergency Condition) *outside* the Service Area will be the lowest of:
    - (i) The amount the Claims Administrator (or a contractor, acting on the Claims Administrator's behalf) has negotiated with the Out-of-Network Service Provider;
    - (ii) The usual and customary charge. The usual and customary charge is a fee or charge the Claims Administrator determines based on provider charge data that the Claims Administrator purchases from a New York State-approved vendor of provider pricing data;
    - (iii) The amount provided to the Claims Administrator by another Blue Cross and Blue Shield Plan; or

- (iv) The Out-of-Network Service Provider's charge.
- (3) The Allowable Expense for services rendered by an Out-of-Network Facility or an Out-of-Network Service Provider in connection with an Emergency Condition is the Out-of-Network Facility's or Out-of-Network Service Provider's charge.
- C. **BlueCard Program.** Like all Blue Cross and Blue Shield Licensees (hereinafter "Plans"), Excellus BlueCross BlueShield participates in a program called the BlueCard Program. The BlueCard Program provides benefits when you are outside the Service Area. When you receive health care services outside the Service Area from a provider that participates with a Blue Cross and Blue Shield Plan, your claims may be processed through the BlueCard Program.
- D. **Calendar Year.** The twelve (12) month period beginning on January 1 and ending on December 31. However, if you were not covered under this Program for this entire period, Calendar Year means the period from the date you became covered until December 31.
- E. **Coinsurance.** A charge, expressed as a percentage of the Allowable Expense, that you must pay for certain services provided under this Program. You are responsible for the payment of any Coinsurance directly to the provider.
- F. **Copayment.** A predetermined charge, expressed as a fixed dollar amount, which you must pay for certain health services provided under this Program. You are responsible for the payment of any Copayments directly to the provider when you receive health services.
- G. **Deductible.** A charge, expressed as a fixed dollar amount, which you must pay once each Calendar Year before the Program will pay certain for certain Benefits covered under this Program during that Calendar Year. (There are special Deductible rules when you have other than individual coverage. See Section Four.)
- H. **Effective Date.** The date your coverage under this Program begins. Coverage begins 12:01 a.m. on the Effective Date.
- I. **Facility.** A Hospital; ambulatory surgery facility; birthing center; dialysis center; rehabilitation facility; Skilled Nursing Facility; hospice; home health agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; institutional provider of mental health or chemical dependence and abuse treatment operating under Article 31 of the New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services; or other provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable). If

you receive treatment outside of New York State, the Facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations to provide a chemical abuse treatment program.

J. **Hospital.** Any short-term acute general hospital facility which is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations; is certified under Medicare; and if located in New York State, is licensed pursuant to Article 28 of the Public Health Law of New York. A Hospital is a licensed institution primarily engaged in providing:

- (1) Inpatient diagnostic and therapeutic services for surgical and medical diagnosis;
- (2) Treatment and care of injured and sick persons by or under the supervision of physicians; and
- (3) Twenty-four (24) hour nursing service by or under the supervision of registered nurses.

None of the following are considered Hospitals:

- (1) Hospitals for treatment of mental illness. If you are a patient in a separate division or unit of a Hospital dedicated to the treatment of mental illness where the average length of stay is more than 30 days, that separate division or unit is not considered a Hospital;
- (2) Places primarily for nursing care;
- (3) Skilled Nursing Facilities;
- (4) Convalescent homes or similar institutions;
- (5) Institutions primarily for custodial care, rest, or as domiciles;
- (6) Health resorts, spas, or sanitariums;
- (7) Infirmarys at schools, colleges, or camps;
- (8) Places primarily for the treatment of chemical dependency and abuse, hospice care, or rehabilitation; or
- (9) Free standing ambulatory surgical centers.

K. **In-Network Provider.** A Facility, Professional Provider, or Provider of Additional Health Services that has a participating provider agreement with Excellus BlueCross BlueShield or any other Blue Cross and/or Blue Shield Plan

to provide health services to persons covered under this Program. Excellus BlueCross BlueShield has provider directories that list the In-Network Providers. Copies of the provider directories are available free of charge upon request.

- L. **Medical Director.** The person designated by Excellus BlueCross BlueShield to monitor quality of care and appropriate utilization of health services.
- M. **Medical Necessity.** See Section Three of this Booklet.
- N. **Member.** Any retired employee of the Group, or an eligible dependent of a retired employee of the Group, who meets all applicable eligibility requirements and for whom the required premium payment has actually been received by the Group (or by Excellus BlueCross BlueShield on behalf of the Group) and who is covered under this Program.
- O. **Mental Illness.** A mental, nervous or emotional condition that, in our sole judgment, has treatable behavioral manifestations that we determine:
  - (1) Is a clinically significant alteration in thinking, mood or behavior, or a combination thereof; and
  - (2) Substantially or materially impairs your ability to function in one or more major life activities; and
  - (3) Has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
- P. **Out-of-Network Provider.** A Facility, Professional Provider, or Provider of Additional Health Services that does not have a participating provider agreement with Excellus BlueCross BlueShield or any other Blue Cross and/or Blue Shield Plan to provide health services to persons covered under this Program.
- Q. **Professional Provider.** A certified and licensed physician; osteopath; dentist; optometrist; chiropractor; registered psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; licensed midwife; speech-language pathologist; audiologist; or any other licensed health care provider who the New York State Insurance Law requires licensed health service corporations to recognize and who charges and bills patients for services. A Professional Provider's services must be rendered within the lawful scope of practice for that type of provider in order to be covered under this Program.
- R. **Provider of Additional Health Services.** A provider of services or supplies covered under this Program (such as diabetic equipment and supplies or ambulance services) that is not a Facility or Professional Provider, and that is: licensed or certified according to applicable state law or regulation; approved by

any applicable accreditation body, and/or recognized by Excellus BlueCross BlueShield for payment under this Program.

- S. **Service Area.** The geographic territory within which Excellus BlueCross BlueShield is licensed to use the BlueCross and BlueShield service marks. The Excellus BlueCross BlueShield Service Area consists of Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Oswego; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson counties.
- T. **Skilled Care.** A service that Excellus BlueCross BlueShield determines is furnished by or under the direct supervision of licensed medical personnel to assure the safety of the patient and achieve the medically desired results as defined by medical guidelines. A service is not considered a skilled service merely because it is performed or supervised by licensed medical personnel. However, it is a service that cannot be safely and adequately self-administered or performed by the average non-medical person without the supervision of such personnel.
- U. **Skilled Nursing Facility.** A facility accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or qualified as a Skilled Nursing Facility under Medicare. The Program will provide coverage for your care in a Skilled Nursing Facility only if Excellus BlueCross BlueShield determines that the care is Skilled Care.
- V. **“You”, “Your”, and “Yours”.** Throughout this Booklet, the words “you”, “your” and “yours” refers to you, the retired employee or member of the Group to whom this Booklet is issued. If other than individual coverage applies, then, in most cases, the word “you” also includes any family members, including domestic partners, who are covered under this Program.



## SECTION TWO - WHO IS COVERED

1. **Who Is Covered Under This Program.** You are eligible if you are a retiree of Group who is eligible for Medicare.

If you selected other than individual coverage, the following members of your family may also be covered:

- A. Your spouse, unless you are divorced or your marriage has been annulled. The term “spouse” means a person of the same or opposite gender that is legally married to you, the retired employee, and who is recognized as a spouse in accordance with the laws of the State of New York.
- B. Your eligible domestic partner. For a person to be your eligible domestic partner, you and he or she must satisfy the requirements as described in the “application for Domestic Partnership” and “Health Care and Dental Benefits for Domestic Partners Questions and Answers.”

The value of the Plan coverage for a retired employee’s domestic partner is treated as taxable income to the retired employee if the domestic partner does not qualify as a dependent under tax law. The employer will comply with all federal and state tax withholding and reporting requirements for domestic partner coverage.

- C. Your children who are under 26 years of age regardless of marital status or student status; provided they do not have access to any other employer-sponsored health coverage through their own or spouse’s employer.
- D. Any unmarried child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap. The condition must have occurred prior to the child’s attainment of age 26. The child's disability must be certified by a physician. You must file an application in the form Excellus BlueCross BlueShield approves to request that the child be included in your family coverage. The Group and Excellus BlueCross BlueShield have the right to check whether a child is and continues to qualify under this Paragraph.
- E. Your unmarried children who are between 26 and 30 years of age, who do not have insurance through the University of Rochester due to attainment of age 26, who do not have insurance through their employer nor are eligible for insurance through their employer, who live, work or reside in New York State or the Service Area and who are not covered by Medicare are also eligible to purchase individual coverage under this Program. You must complete a Certification Form with Excellus BlueCross BlueShield in order to obtain coverage for your children under this provision.

The term “child or children” include your natural children; legally adopted children; stepchildren; children who are placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction; and children for which you are the proposed adoptive parent and for whom you have a legal obligation for total or partial support during the waiting period prior to the adoption period.

Excellus BlueCross BlueShield and the Group have the right to request and be furnished with such proof as may be needed to determine the eligibility status of a prospective Member and all prospective dependents for coverage under this Program.

2. **Newborn Child.** If you have a type of coverage that would cover a newborn, your newborn child will be covered at birth, provided you notify your employer within 30 days of the birth by completing an enrollment form to add the child to your coverage and providing any documentation requested by your employer. If you are changing your type of coverage (for example to family coverage) in order to cover the newborn child, within 30 days of the birth, you must complete an enrollment form to extend your coverage to include your child and provide any requested documentation. If you do not complete the enrollment form and provide any requested documentation within 30 days of the birth, coverage of the child will not become effective until the next open enrollment period after your employer receives the completed enrollment form. If a child of yours who is covered under this Program gives birth, your newborn grandchild will not be covered (unless such grandchild is placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction). In this case, your grandchild will be covered the same as any other child in accordance with Subparagraph 1C, D or E above.
3. **Adopted Newborns.** If you have a type of coverage that would cover a newborn, or switch to a type of coverage that will cover a newborn, in accordance with Paragraph 3 above, the Program will cover a proposed adoptive newborn from the moment of birth if you (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the Hospital after birth and you file a petition pursuant to §115-C of the New York State Domestic Relations Law within 30 days of the infant's birth. However, the Program will not provide coverage for the initial Hospital stay of an adopted newborn if one of the child's natural parents has coverage available to cover the newborn's initial Hospital stay. The Program also will not provide coverage for the newborn if a notice of revocation of the adoption has been filed or one of the natural parents revokes their consent to the adoption. If the Program provides coverage of an adopted newborn and notice of the revocation of the adoption is filed or one of the natural parents revokes their consent, the Program will be entitled to recover any sums paid by it for care of the adopted newborn.
4. **Types Of Coverage Other Than Individual Coverage.** The Program offers different types of coverage in addition to individual coverage:

- A. Family Coverage - If family coverage applies, then you, the retired employee, your spouse or eligible domestic partner, and your children, as described above, are covered;

The names of all persons covered under this Program must have been specified on the enrollment form for this Program, or provided to Excellus BlueCross BlueShield as described in Paragraph 8 below. No one else can be substituted for those persons. The Group and Excellus BlueCross BlueShield have administrative rules to determine which types of coverage are available to members of the Group. You are only entitled to the types of coverage for which the Group (or Excellus BlueCross BlueShield on behalf of the Group) receives your contribution and for which you are otherwise eligible. You may call Excellus BlueCross BlueShield if you have any questions about which type of coverage applies to you.

5. **When Coverage Begins.** Coverage under this Program will begin as follows:

- A. If you, the retired employee or member of the Group, elect coverage before becoming eligible for coverage or within 30 days of becoming eligible, coverage begins at 12:01 a.m. on the date you become eligible;
- B. If you, the retired employee or member of the Group, do not elect coverage upon becoming eligible or within 30 days of becoming eligible, you must wait until the Group's open enrollment period, except as provided in Paragraph 7 below. Coverage then begins at 12:01 a.m. on the next contribution due date after the next open enrollment period; or
- C. If you, the retired employee, marry or enter into a domestic partnership while covered, and Excellus BlueCross BlueShield receives notice of such marriage or the domestic partnership within 30 days thereafter, coverage for the spouse or domestic partner starts at 12:01 a.m. on the date of such marriage or commencement of the domestic partnership; or, if later, the date your election form is completed; otherwise, coverage for your spouse or domestic partner will start at 12:01 a.m. on the next contribution due date after the next open enrollment period.

6. **When You Reject Initial Enrollment, But Need to Enroll for Coverage Prior to The Group's Open Enrollment Period to Enroll For Coverage.** If you, the retired employee, reject initial enrollment under this Program, you may enroll for coverage if all of the following conditions are met:

- A. You were covered under another plan or contract when coverage was initially offered; and
- B. Coverage was provided in accordance with continuation required by state or federal law and was exhausted; or coverage under the other plan or contract was terminated because you lost eligibility for one or more of the following reasons:

- (1) Termination of employment;
  - (2) Termination of the other plan or contract;
  - (3) Death of the spouse or domestic partner;
  - (4) Legal separation, divorce, or annulment, or termination of a domestic partnership;
  - (5) Reduction in the number of hours worked;
  - (6) The employer or other group ceased its contribution toward the premium for the other plan or contract; and
- C. You apply for coverage under this Program within 30 days after termination for one of the reasons set forth in Subparagraph B above.

If you enroll for coverage pursuant to this paragraph, your coverage will begin at 12:01 a.m. on the date of the loss of coverage or the date your election form is completed, whichever is later.

## 7. **Notification Of Change In Your Coverage.**

- A. **To Add a Spouse, Domestic Partner or Child.** If you need to add a spouse, domestic partner or child to your coverage, you must complete and return to the Group an enrollment form for this purpose together with any requested documentation. The addition of a child will be effective as of the date of birth or adoption making the child eligible for coverage under Paragraph 2, if you return to your employer a completed enrollment form and requested documents within 30 days of the birth or adoption. The addition of a spouse, domestic partner or other dependent will be effective as of the date of the marriage or commencement of a domestic partnership, or other qualifying event making such individual eligible for coverage under this section or the date the election form is completed, whichever is later. If you return to your employer a completed enrollment form and requested documents within 30 days of the applicable event, If you do not return a completed election form and the requested documentation within 30 days, you will not be able to add the dependent until you reach the annual open enrollment period or experience another qualifying event. Any changes requested during the annual open enrollment period, including the addition of a dependent, will be effective the following January 1.
- B. **When Coverage of a Spouse, Domestic Partner or Child Terminates.** If you have other than individual coverage, you should notify your employer of any event that affects your coverage, such as, your divorce or termination of a domestic partnership; the death of your spouse or domestic partner; or a child

reaching the age at which coverage terminates, or otherwise experiencing an event which would normally result in termination of dependent coverage. Upon your request, the Group will provide you with an enrollment form for that purpose. If such change results in you seeking a different type of coverage at a lower contribution level (such as a switch to individual coverage), the form and requested documentation must be returned within 30 days of the event. The change in contribution level will occur during the pay period in which the change in coverage becomes effective. Nothing in this Subparagraph B is designed to affect the provisions of Section Sixteen governing terminations of coverage. This Subparagraph B only involves the effective date of changes in required contribution levels due to terminations of coverage under Section Sixteen.

If you think there are reasons coverage of the person experiencing the change should continue, you must notify your employer of the reasons for the continuation of the coverage on an enrollment form provided by the Group to you for that purpose, and provide any documentation that is requested by the Group, no later than 60 days after the date on which dependent coverage would usually terminate.

Removing a dependent due to a qualifying event will be effective as of the date of the event or the date the enrollment form is completed, whichever is later. However, any claims incurred after a dependent becomes ineligible will not be paid by the Program.

## SECTION THREE – MEDICAL NECESSITY AND PRIOR APPROVAL

1. **Care Must Be Medically Necessary.** The Program will provide coverage for the covered benefits described in this Booklet as long as the hospitalization, care, service, technology, test, treatment, drug, or supply (collectively, “Service”) is Medically Necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the Service does not make it Medically Necessary or mean that the Program has to provide coverage for it.

Excellus BlueCross BlueShield will decide whether care was Medically Necessary. Excellus BlueCross BlueShield will base its decision in part on a review of your medical records. Excellus BlueCross BlueShield will also evaluate medical opinions it receives. This could include the medical opinion of a professional society, peer review committee, or other groups of physicians.

In determining if a Service is Medically Necessary, Excellus BlueCross BlueShield may also consider:

- A. Reports in peer reviewed medical literature;
- B. Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- C. Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment;
- D. The opinion of health professionals in the generally recognized health specialty involved;
- E. The opinion of the attending Professional Providers, which have credence but do not overrule contrary opinions; and
- F. Any other relevant information brought to its attention.

Services will be deemed Medically Necessary only if:

- A. They are appropriate and consistent with the diagnosis and treatment of your medical condition;
- B. They are required for the direct care and treatment or management of that condition;
- C. If not provided, your condition would be adversely affected;

- D. They are provided in accordance with community standards of good medical practice;
  - E. They are not primarily for the convenience of you, your family, the Professional Provider, or another provider;
  - F. They are the most appropriate service and rendered in the most efficient and economical way and at the most economical level of care which can safely be provided to you; and
  - G. When you are an inpatient, your medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided to you in any other setting (e.g., outpatient, physician's office, or at home).
2. **Service Or Care Must Be Approved Standard Treatment.** Except as otherwise required by law, no service or care rendered to you will be considered Medically Necessary unless Excellus BlueCross BlueShield determines that the service or care is: consistent with the diagnosis and treatment of your medical condition; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative.
  3. **Services Subject To Prior Approval.** Excellus BlueCross BlueShield's prior approval is required before you receive certain services covered under this Program. The services subject to prior approval are: all services relating to organ transplants.
  4. **Prior Approval Procedure.** Members who seek coverage for the services listed in Paragraph 3 above must call Excellus BlueCross BlueShield at the number indicated on their identification card to have the care pre-approved. It is requested that you call at least seven days prior to a planned inpatient admission.

If you are hospitalized in cases of an Emergency Condition involving any of these services, you should call Excellus BlueCross BlueShield within 24 hours after your admission or as soon thereafter as reasonably possible. However, you must call Excellus BlueCross BlueShield as soon as it is reasonably possible in order for any follow-up care to be covered without the reduction described in Paragraph 6 of this section. The availability of an organ for transplantation resulting in the necessity for an immediate admission for implantation shall be considered an Emergency Condition for purposes of this Paragraph.

After receiving a request for approval, Excellus BlueCross BlueShield will review the reasons for your planned treatment and determine if benefits are available. Excellus BlueCross BlueShield will notify you and your Professional Provider of its decision by telephone and in writing within three business days of receipt of all necessary information. If your treatment involves continued or extended health care services, or additional services for a course of continued treatment, Excellus BlueCross BlueShield

will notify you and your Professional Provider within one business day of receipt of all necessary information.

5. **Your Right To Appeal.** If you or your Professional Provider disagrees with Excellus BlueCross BlueShield's decision, you may appeal by writing to Excellus BlueCross BlueShield within 60 days of the date of its decision. You should describe the reasons why you disagree with Excellus BlueCross BlueShield's decision and provide any further information you think is relevant. Excellus BlueCross BlueShield will review your appeal, and advise you of the findings of its review within 30 days after it receives the medical records necessary for the review. Any appeals must be made in writing to: 165 Court Street, Rochester, NY 14647.
  
6. **Failure To Seek Approval.** If you fail to seek Excellus BlueCross BlueShield's prior approval for benefits subject to this Section Three, the Program will pay an amount \$500 less than it would otherwise have paid for the care, or it will pay only 50% of the amount it would otherwise have paid for the care, whichever results in a greater benefit for you. You must pay the remaining charges. The Program will pay the amount specified above only if it determines the care was Medically Necessary even though you did not seek prior approval. If it is determined that the services were not Medically Necessary, you will be responsible for paying the entire charge for the service.



## SECTION FOUR - COST SHARING EXPENSES

1. **Annual Major Medical Deductible.** You and your dependent (if you have family coverage) are each responsible for the payment of a Deductible in each Calendar Year for the services covered under the major medical portion of this Program to which the Deductible applies (as is stated in the Section of this Booklet where the particular service is described). You and your dependents (if you have family coverage) must pay the first \$114 of Allowable Expenses incurred during the Calendar Year. If you have family coverage, you and your dependents must pay the first \$228 of Allowable Expenses incurred during the Calendar Year. No more than \$114 of a Member's Deductible can be applied to the family maximum limit of \$228.
  - A. Carry-Over of Prior Year's Deductible Payments. Covered expenses incurred and counted toward a Deductible during the calendar months of October, November and December shall also be applied toward the deductible for the next succeeding Calendar Year.
  - B. Multiple Injuries in One Accident. If you and your covered spouse are hurt in the same accident, only one individual deductible amount must be paid before coverage will be available for care and services arising out of that accident.
  
2. **Annual Prescription Drug Deductible.** You and your dependent (if you have family coverage) are each responsible for the payment of a Deductible in each Calendar Year for Prescription Drugs covered under the Prescription Drug portion of this Program. This Prescription Drug Deductible is separate from and in addition to your major medical Deductible. You and your dependents (if you have family coverage) must pay the first \$751 of Allowable Expenses incurred during the Calendar Year. If you have family coverage, you and your dependents must pay the first \$1,502 of Allowable Expenses incurred during the Calendar Year. No more than \$751 of a Member's Deductible can be applied to the family maximum limit of \$1,502.

Carry-Over of Prior Year's Deductible Payments. Covered expenses incurred and counted toward a deductible during the calendar months of October, November and December shall also be applied toward the Deductible for the next succeeding Calendar Year.
  
3. **Major Medical Maximum Annual Deductible and Coinsurance Amounts.** When you have expended \$300 for Deductibles and Coinsurance for Major Medical benefits other than Prescription Drug Coverage in any Calendar Year, this Program will provide coverage for 100% of the Allowable Expense for the remainder of the Calendar Year for Major Medical Benefits. If you have other than individual coverage, the \$300 maximum applies to each person covered under this Program. However, when two members of the same family covered under this Program have paid an aggregate of \$600 for Deductibles and Coinsurance in any Calendar Year for Major Medical benefits, the Program will provide coverage for 100% of the Allowable Expense for the balance of the Calendar Year for Major Medical Benefits. Amounts you pay for outpatient Prescription

Drug Coverage do not count towards the \$300 (individual)/\$600 (family) out-of-pocket limitation described above.

4. **Prescription Drug Maximum Annual Deductible and Coinsurance Amounts.** When you have expended \$1,700 for Deductibles and Coinsurance for Prescription Drug coverage in any Calendar Year, the Program will provide coverage for 100% of the Allowable Expense for the remainder of the Calendar Year. If you have other than individual coverage, the \$1,700 maximum applies to each person covered under this Program. However, when two members of the same family covered under this Program have paid an aggregate of \$3,400 for Deductibles and Coinsurance in any Calendar Year, the Program will provide coverage for 100% of the Allowable Expense for Prescription Drug Coverage for the balance of the Calendar Year. This maximum annual Deductible and Coinsurance amount is separate from and in addition to the maximum annual Deductible and Coinsurance amount under the major medical portion of this Program.
5. **Copayments.** The Copayments you must pay for covered services when you are entitled to certain benefits are set forth in the Section of this Booklet where the particular service is described. Unless otherwise stated, a Copayment is due each time you receive the applicable health services, including each refill of a Prescription Drug.
6. **Coinsurance.** Except where stated otherwise, after you have satisfied the annual Deductible, you will be responsible for a percentage of the Allowable Expense incurred for services under this Program. The Coinsurance amounts you must pay are set forth in the Section of this Booklet where the particular service is described.

## SECTION FIVE - INPATIENT CARE

1. **In A Facility.** If you are a registered bed patient in a Facility, the Program will provide coverage for most of the services provided by the Facility, subject to the conditions and limitations in Paragraph 3 below. The services must be given to you by an employee of the Facility, the Facility must bill for the services, and the Facility must retain the money collected for the services.
  
2. **Services Not Covered.** The Program will not provide coverage for:
  - A. Additional charges for special duty nurses;
  
  - B. Private room, unless it is Medically Necessary for you to occupy a private room. If you occupy a private room in a Facility and Excellus BlueCross BlueShield determines that a private room is not Medically Necessary, the Program's coverage will be based upon the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room;
  
  - C. Blood, except the Program will provide coverage for blood required for the treatment of hemophilia. However, the Program will provide coverage for blood and blood products when participation in a voluntary blood replacement program is not available to you;
  
  - D. Non-medical items, such as telephone or television rental;
  
  - E. Medications, supplies, and equipment (other than internal prosthetics), which you take home from the Facility;
  
  - F. Custodial care (See Section Fourteen, Paragraph 8); or
  
  - G. Mental health services: (a) for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or to a custodial facility for youth operated by the office of children; (b) solely because such services are court-ordered; (c) that are court ordered; (d) that are cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs; or (e) that are otherwise excluded under the Program.
  
3. **Conditions For Inpatient Care; Limitations On Number Of Days Of Care; Payments for Inpatient Care.** Inpatient Facility care is subject to the following conditions and limitations:
  - A. **Inpatient Hospital Care.** The Program will provide coverage when you are required to stay in a Hospital for acute medical or surgical care and are not

admitted to the hospital for mental health care or for diagnosis and treatment of chemical dependence and/or abuse.

**Basic Benefit.** Covered in full less any Medicare payment for up to 120 days of care.

**Major Medical Benefit.** Coverage for additional days will be covered at 80% of the Allowable Expense, after Deductible, less any Medicare payment.

- B. **Mental Health Care.** The Program will provide coverage for inpatient acute mental health care in a Facility or in a Hospital as defined by subdivision 10 of Section 1.03 of the New York Mental Hygiene Law.

**Basic Benefit.** For days of admission 61-120, coverage will be provided for the Medicare Part A deductible and hospital coinsurance.

**Major Medical Benefit.** Coverage for additional days will be covered at 80% of the Allowable Expense, after Deductible.

The Program will also provide coverage for care in a licensed night or day care program for mental health care when it is provided in a licensed night care or day care center maintained by the Facility on its premises and for overnight accommodations in a licensed night care center. A day/night care center is an ambulatory treatment center that provides a medically supervised alternative to inpatient treatment. The Program will only provide coverage for the care if you remain in the night care or day care center for at least 3 continuous hours. One night's care in a night care or one day's care in a day care center will be considered inpatient care and will be counted as one day of Facility care.

If you receive care in a residential treatment facility approved by Excellus BlueCross BlueShield, in lieu of inpatient mental health care, one night's care will be counted as one day of Facility care. A residential treatment facility provides a program of treatment rendered in a Facility that provides 24-hour residential care to patients who do not require acute care services or 24-hour nursing care.

The Program will also provide coverage for medical visits by a Professional Provider on any day of mental health care covered above. The Program will not provide coverage for medical visits by Facility employees or interns, even if they are Professional Providers. The Professional Providers visits must be documented in the Facility's records. The Program will only cover one visit per day per Professional Provider.

- C. **Inpatient Detoxification.** The Program will provide coverage for active treatment for detoxification needed because of chemical dependence. Coverage is available only for services rendered in and billed by:
- (1) A Facility in New York State which is certified by the Office of Alcoholism and Substance Abuse Services;
  - (2) A program that Excellus BlueCross BlueShield recognizes as a chemical dependence and abuse treatment program; or
  - (3) A Facility in another state that Excellus BlueCross BlueShield recognizes, is approved by the Joint Commission on Accreditation of Health Care Organizations as an alcoholism or chemical dependence and abuse treatment program, and meets the appropriate state licensing. If a governmental hospital meets these criteria, services rendered there will be covered unless no charge would have been made in the absence of coverage under this Program.

The Program will also provide coverage for medical visits by a Professional Provider on any day of detoxification covered above. The Program will not provide coverage for medical visits by Facility employees or interns, even if they are Professional Providers. The Professional Providers visits must be documented in the Facility's records. The Program will only cover one visit per day per Professional Provider.

**Basic Benefit.** For days of admission 61-120, coverage will be provided for the Medicare Part A deductible and hospital coinsurance Benefits under this provision will be combined with the Inpatient Chemical Dependency Benefit.

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

- D. **Skilled Nursing Facility.** The Program will provide coverage for care in a Skilled Nursing Facility if Excellus BlueCross BlueShield determines that hospitalization would otherwise be Medically Necessary for the care of your condition, illness, or injury for up to 240 days per single confinement

**Basic Benefit.** Benefit will be covered in full up to 120 days.

**Major Medical Benefit.** Coverage for additional days will be covered at 80% of the Allowable Expense, after Deductible.

- E. **Inpatient Physical Rehabilitation.** The Program will provide coverage for comprehensive physical medicine and rehabilitation (chemical dependence and abuse programs are excluded) for a condition that in the judgment of your

Provider and the Medical Director can reasonably be expected to result in significant improvement within a relatively short period of time.

**Basic Benefit.** For the first 120 days of care, coverage will be provided for the Medicare Part A deductible, and the benefit will be covered in full.

**Major Medical Benefit.** Additional days will be covered at 80% of the Allowable Expense, after Deductible.

- F. **Inpatient Chemical Dependence and Abuse Rehabilitation.** The Program will provide coverage for the active treatment for rehabilitation of chemical dependence and abuse upon the diagnosis of chemical dependence and abuse up to 30 days per Calendar Year and 2 admissions per Lifetime.

**Basic Benefit.** For days 61-120, coverage will be provided for the Medicare Part A inpatient deductible and the hospital coinsurance.

**Major Medical Benefit.** Additional days will be covered at 80% of the Allowable Expense, after Deductible.

4. **Maternity Care.** The Program provides coverage for inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, if covered under the Program, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. The Program will also provide coverage for any additional days of such care that are determined to be Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum coverage period, the Program will provide coverage of the home care visit furnished by the type of home care agency described in Section Seven of this Booklet. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. The Program's coverage of this home care visit shall not be subject to any Coinsurance or Deductible amounts.

**Basic Benefit.** For days 61-120, coverage will be provided for the Medicare Part A inpatient deductible and the hospital coinsurance

**Major Medical Benefit.** Additional days will be covered at 80% of the Allowable Expense, after Deductible. **Routine newborn nursery care is not covered.**

5. **Mastectomy Care.** The Program's coverage of inpatient Hospital care includes coverage of an inpatient Hospital stay following a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer. The length of stay will be determined

by you and your Professional Provider. The Program will also provide coverage for prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

6. **Infertility Treatment Services.** The Program will provide coverage for Medically Necessary inpatient Hospital care in connection with infertility treatment services provided by a Professional Provider pursuant to Section Nine, Paragraph 19.
7. **Internal Prosthetic Devices.** The Program covers inpatient Hospital care for internal prostheses that are surgically implanted and Medically Necessary for anatomical repair or reconstructive purposes. Internal prosthetic devices are designed to replace all or part of a permanently inoperative, absent, or malfunctioning body organ. Examples of internal prosthetic devices include cardiac pacemakers, implanted cataract lenses, and surgically implanted hardware necessary for joint repair or reconstruction.

**Basic Benefit.** Covered in full.

## SECTION SIX - OUTPATIENT CARE

The Program will provide coverage for the same services it would cover if you were an inpatient in connection with the care described below when given to you in the outpatient department of a Facility. As in the case of inpatient care, the service must be given by an employee of the Facility, the Facility must bill for the service, and the Facility must retain the money collected for the service.

1. **Care In Connection With Surgery.** The Program will only provide coverage if Excellus BlueCross BlueShield determines that it was necessary to use the Facility to perform the surgery.

**Basic Benefit.** Covered in full.

2. **Pre-Admission Testing.** The Program will provide coverage for tests ordered by a physician that are given to you as a preliminary to your admission to the Facility as a registered bed patient for surgery if all of the following conditions are met:
  - A. They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;
  - B. A reservation has been made for the Facility bed and/or the operating room before the tests are given;
  - C. You are physically present at the Facility when these tests are given; and
  - D. Surgery actually takes place within 7 days after the tests are given.

**Basic Benefit.** Covered in full.

3. **Diagnostic and Routine Procedures.** The Program will provide coverage for diagnostic and routine procedures, including x-rays, imaging, and laboratory procedures.

**Basic Benefit.** Covered in full.



4. **Radiation Therapy And Chemotherapy.** The Program will provide coverage for radiation therapy and chemotherapy.

**Basic Benefit.** Covered in full.

5. **Hemodialysis.** The Program will provide coverage for hemodialysis treatments of an acute or chronic kidney ailment.

**Basic Benefit.** Covered in full.

6. **Mammography Screenings.** The Program will provide coverage for mammography screenings for occult breast cancer pursuant to the limitations described below. The screenings may be provided in the outpatient department of a Facility under this Section or in a Professional Provider's office pursuant to Section Nine, Paragraph 12. The Program's coverage for routine mammography screenings under this Section and Section Nine, Paragraph 12 is subject to the following aggregate limitations:

- A. **Women at Risk.** The Program will provide coverage for mammograms for women of any age who have a prior history of breast cancer or who have a first degree relative (such as a child, mother, or sister), or a paternal or maternal grandmother who has a prior history of breast cancer, if the mammogram is recommended by a physician.
- B. **Women 35 Through 39 Years of Age.** The Program will provide coverage for one baseline mammogram for women 35 through 39 years of age.
- C. **Women 40 Years of Age And Older.** The Program will provide coverage for one mammogram in each Calendar Year for women 40 years of age and older.

Mammography screening shall mean an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films, and cassettes, with an average glandular radiation dose of less than 0.5 rem per view per breast.

**Basic Benefit.** Routine mammography screenings are covered in full.

7. **Cervical Cytology Screenings (Pap Smears).** The Program will provide coverage, subject to the limitations described below, for two screenings for cervical cancer and its precursor states each Calendar Year for women 18 years of age or older. The screenings may be provided in the outpatient department of a Facility under this Section or in a Professional Provider's office pursuant to Section Nine, Paragraph 13. The Program's coverage under this Section and Section Nine, Paragraph 13 is subject to the 2-visit limit above. Cervical cytology screening shall mean a pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

**Basic Benefit.** Covered in full.

8. **Mental Health Visits.** The Program will provide coverage for care in a facility that has an operating certificate issue pursuant to Article 31 of the New York Mental Hygiene Law or in a facility operated by the Office of Mental Health.

The Program will not provide coverage for mental health services: (a) for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or to a custodial facility for youth operated by the office of children; (b) solely because such services are court-ordered; (c) that are cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs; or (d) that are otherwise excluded under the Program.

**Basic Benefit.** Covered in full.

9. **Chemical Dependency.** The Program will provide coverage for outpatient visits in a Facility for the diagnosis and treatment of chemical dependence. Each individual visit must consist of at least one of the following: individual or group chemical dependence counseling; activity therapy; and diagnostic evaluations by a Professional Provider to determine the nature and extent of your illness or disability. The Program will not provide coverage for visits that consist primarily of participation in programs of a social, recreational, or companionship nature.

**Basic Benefit.** Covered in full.

10. **Covered Therapies.** The Program will provide coverage for related rehabilitative physical therapy and physical, occupational and speech therapy when services are rendered by a licensed physical therapist, occupational therapist, or speech language pathologist or audiologist and when Excellus BlueCross BlueShield determines that your condition is subject to significant clinical improvement through relatively short-term therapy.

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

11. **Cardiac Rehabilitation.** The Program will provide coverage for Medically Necessary cardiac rehabilitation programs on referral by a Professional Provider.

**Basic Benefit.** Covered in full.

12. **Pulmonary Rehabilitation.** The Program will provide coverage for one pulmonary rehabilitation program per lifetime, based on patient risk factors.

**Basic Benefit.** Covered in full.

## SECTION SEVEN - HOME CARE

1. **Type Of Home Care Provider.** The Program will provide coverage for home care visits given by a certified home health agency or a licensed home care services agency if your Professional Provider and the Medical Director determine that the visits are Medically Necessary.

If operating outside of New York State, the home health agency or home care services agency must be qualified by Medicare.

2. **Eligibility For Home Care.** The Program will provide coverage for home care only if all the following conditions are met:
  - A. A home care treatment plan is established and approved in writing by your Professional Provider;
  - B. If provided by a certified or licensed home health agency or home care services agency, you apply through your Professional Provider to the home health agency or home care services agency with supporting evidence of your need and eligibility for home care; and
  - C. The home care is related to an illness or injury for which you were hospitalized or for which you otherwise would have been hospitalized or confined in a Skilled Nursing Facility. This home care must be Medically Necessary at a skilled or acute level of care.

You will not be entitled to coverage of any home care after the date it is determined that you no longer need such services.

3. **Home Care Services Covered.** Home health care will consist of one or more of the following:
  - A. Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse;
  - B. Part-time or intermittent home health aide services which consist of primarily rendering direct care to you;
  - C. Physical, occupational, or speech therapy if provided by the home health care agency; and
  - D. Medical supplies, drugs, and medications prescribed by your physician and laboratory services by or on behalf of the home health agency or home care services agency to the extent such items would have been covered under this Program if you were an inpatient in a Hospital or Skilled Nursing Facility.

For purposes of this paragraph, “part-time or intermittent” means no more than 35 hours per week.

4. **Failure To Comply With Home Care Treatment Plan.** If you fail or are unable to comply with the home care treatment plan, benefits for your plan of home care will be terminated.
5. **Number Of Visits.** The Program will provide coverage for an unlimited number of visits per Calendar Year.
6. **Payments For Home Care.**

**Basic Benefit.** Covered in full.

## SECTION EIGHT - HOSPICE CARE

1. **Eligibility for Benefits.** In order to receive these benefits, which are non-aggressive services provided to maintain the comfort, quality, and dignity of life to the terminally ill patient, you must meet the following conditions:
  - A. The attending physician estimates your life expectancy to be six months or less; and
  - B. Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.
2. **Hospice Organizations.** In New York State the Program will provide coverage only for hospice care provided by a hospice organization which has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the hospice organization must have an operating certificate issued under criteria similar to those used in New York by a state agency in the state where the hospice care is provided, or it must be approved by Medicare.
3. **Hospice Care Benefits.** The Program will provide coverage for the following services when provided by a hospice:
  - A. Bed patient care provided by the hospice organization either in a designated hospice unit or in a regular hospital bed;
  - B. Day care services provided by the hospice organization;
  - C. Home care and outpatient services which are provided and billed through the hospice and which may include at least the following:
    - (1) Intermittent nursing care by an R.N., L.P.N. or home health aide;
    - (2) Physical therapy;
    - (3) Speech therapy;
    - (4) Occupational therapy;
    - (5) Respiratory therapy;
    - (6) Social services;
    - (7) Nutritional services;
    - (8) Laboratory examinations, X-rays, chemotherapy, and radiation therapy when required for control of symptoms;

- (9) Medical supplies;
- (10) Drugs and medications that require a prescription by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary; provided that the Program will not provide coverage when the drug or medication is of an experimental nature;
- (11) Durable medical equipment; and
- (12) Bereavement services provided to your family during illness, and until one year after death; and

D. Medical care provided by a physician.

4. **Number Of Days Of Care.** The Program will provide coverage for an unlimited number of home care visits. The Program will provide coverage for up to five visits for bereavement counseling services to your family, either before or after your death. The Program will provide coverage for up to five respite visits to your family before your death.

5. **Payments For Hospice Care.**

**Basic Benefit.** Covered in full.

## SECTION NINE - PROFESSIONAL SERVICES

The Program will provide coverage for the services of Professional Providers described below.

1. **Surgical Care.** This includes operative procedures for the treatment of disease or injury. It includes any pre-operative and post-operative care usually rendered in connection with such procedures. Pre-operative care includes pre-operative examinations that result in a decision to operate. Surgical care also includes endoscopic procedures and the care of fractures and dislocations of bones.

The Program will also provide coverage for surgical services including all stages of reconstructive surgery on a breast on which a mastectomy has been performed. The Program will also provide coverage for reconstructive surgical procedures on the other breast to produce a symmetrical appearance. Coverage will be provided for all such services rendered in the manner determined appropriate by you and your Professional Provider.

- A. **Inpatient Surgery.** The Program will provide coverage for surgical procedures performed while you are an inpatient in a Hospital or other Facility.

**Basic Benefit.** Covered in full.

- B. **Outpatient Surgery.** The Program will provide coverage for surgical procedures performed in the outpatient department of a Hospital or other Facility or in a Hospital-based or freestanding ambulatory surgery facility.

**Basic Benefit.** Covered in full.

- C. **Office Surgery.** The Program will provide coverage for surgical procedures performed in the Professional Provider's office.

**Major Medical Benefit.** Covered at 80%, subject to Deductible.

3. **Anesthesia Services.** This includes the administration of necessary anesthesia and related procedures in connection with a covered surgical service. The administration and related procedures must be done by a Professional Provider other than the Professional Provider performing the surgery or an assistant. The Program will not provide coverage for the administration of anesthesia for a procedure not covered by the Program.

**Basic Benefit.** Covered in full.

4. **Additional Surgical Opinions.** The Program will provide coverage for a second opinion with respect to proposed surgery under the following conditions:

- A. The Program will provide benefits when:



- (1) You seek the second surgical opinion after your surgeon determines your need for surgery; and
  - (2) The second surgical opinion is rendered by a physician
    - (a) Who is a board certified specialist; and
    - (b) Who, by reason of his or her specialty, is an appropriate physician to consider the proposed surgical procedure; and
  - (3) The second surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under this Program if such surgery was performed; and
  - (4) You are examined in person by the physician rendering the second surgical opinion; and
  - (5) The specialist who renders the opinion does not also perform the surgery.
- B. The Program will provide coverage for a third surgical opinion if the first two opinions do not agree. The rules described above also apply to the third surgical opinion.

**Major Medical Benefit.** Covered in full.

5. **Second Medical Opinions.** The Program will provide coverage for an office visit in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer. A positive diagnosis of cancer occurs when you are diagnosed by your Professional Provider as having some form of cancer. A negative diagnosis of cancer occurs when your Professional Provider performs a cancer-screening exam on you and finds that you do not have cancer, based on the exam results. The Program will also provide coverage for a second medical opinion concerning any recommendation of a course of treatment of cancer. The second medical opinion must be rendered by an appropriate specialist, including but not limited to, a specialist associated with a specialty care center for the treatment of cancer

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

6. **Maternity Care.** The Program will provide coverage for:
- A. **Normal Pregnancy.** Maternity care includes the first visit upon which a positive pregnancy test is determined. It also includes all subsequent prenatal and postpartum care. These benefits include the services of a licensed midwife, under qualified medical direction, affiliated or practicing in conjunction with a Facility licensed under the New York Public Health Law. Any laboratory testing or

diagnostic imaging is not covered under this Paragraph. These items are subject to the applicable coverage and cost sharing under the appropriate provisions (such as Section 9, Paragraph 8(B)(1) and Section 9, Paragraph 9).

**Basic Benefit.** Covered in full.

- B. **Complications of Pregnancy and Termination.** The Program will provide coverage for complications of pregnancy and for termination of pregnancy, including elective termination of pregnancy.

**Basic Benefit.** Covered in full.

- C. **Anesthesia.** The Program will provide coverage for delivery anesthesia.

**Basic Benefit.** Covered in full.

7. **In-Hospital Medical Services.** The Program will provide coverage for medical visits by a Professional Provider on any day of hospitalization covered under Section Five. The Program will not provide coverage for medical visits by Facility employees or interns, even if they are Professional Providers.

For Medically Necessary diagnosis and treatment of Mental Illnesses, the Program will provide coverage for visits by a psychiatrist or psychologist licensed to practice in New York, a licensed clinical social worker who meets the requirements of Section 4303(n) of the New York Insurance Law, a professional corporation or a university faculty practice corporation for Active Treatment or for treatment in a partial hospitalization program (on any day of inpatient facility care or partial hospitalization covered under the Program).

The Professional Provider's services must be documented in the Facility records. The Program will cover only one visit per day per Professional Provider. However, services rendered by up to two Professional Providers on a single day will be covered if the two Professional Providers have different specialties and are treating separate conditions.

**Basic Benefit.** Covered in full.

8. **Medical Care In a Professional Provider's Office.** Unless otherwise provided below, the following services are covered in a Professional Provider's office:

- A. **Preventive Health Services.** The Program will provide coverage for the following health prevention programs rendered in the Professional Provider's office or by other providers designated by the Medical Director:

**Routine Physical Examinations.** The Program will provide coverage for periodic adult routine physical examinations in accordance with the United States Task Force on Preventative Care. Specifically, for covered individuals age 18

and older the Program will cover one routine physical examination per Calendar Year as follows:

**Basic Benefit.** Covered in full.

**Well Child Visits and Immunizations.** The Program will provide coverage for well child visits in accordance with the schedule recommended by the United States Task Force on Preventative Care. Specifically, well child visits will be covered as follows:

Age less than 1 year – 7 visits  
Age 1- 2 years – 4 visits  
Age 2 – 2 visits  
Age 3 through 18 – 1 visit per year

The Program will also cover childhood immunizations recommended by the American Academy of Pediatrics, in accordance with the Academy's recommended schedule.

The Program will cover services typically provided in conjunction with a well-child visit. Such services include at least: complete medical histories; a complete physical exam; developmental assessments; anticipatory guidance; laboratory tests performed in the practitioner's office or in a clinical laboratory; and/or other services ordered at the time of the well child visit.

**Basic Benefit.** Covered in full.

**B. Laboratory and Pathology Services.** The Program will provide coverage for diagnostic and routine laboratory and pathology services.

**Basic Benefit.** Covered in full.

**C. Other Health Services.**

(1) **Vision Examinations.** The Program will provide coverage for diagnostic eye examinations to determine disease or injury to the eye. The Program will not provide coverage for vision examinations required by your employer as a condition of employment or rendered through a medical department, clinic, or similar service provided or maintained by your employer.

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

(2) **Eyewear.** The Program will provide coverage for the initial prescription for contact lenses or lenses and frames after cataract surgery.

**Major Medical Benefit.** After any Medicare payment, eyewear is covered at 80% of the Allowable Expense, after Deductible.

- (3) **Hearing Examinations.** The Program will provide coverage for diagnostic hearing examinations to determine disease or injury to the ear.

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

- (4) **Hearing Aids.** The Program will pay for hearing aids prescribed by a physician or audiologist if they are needed because of an accidental injury.

**Major Medical Benefit.** Coverage will be provided in full after Deductible for accidental injury, less any Medicare payment.

- D. **Diagnostic Office Visits.** The Program will provide coverage for diagnostic office visits.

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

- E. **Office Consultations.** The Program will provide coverage for consultations billed by a physician. A consultation is professional advice given by a physician to your attending physician upon request of your attending physician.

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

9. **Diagnostic and Routine Imaging Examinations and Diagnostic Radioactive Isotope Procedures.** Subject to the provisions below, the Program will provide coverage for the professional component of x-ray examinations; radioactive isotope; ultrasound; CAT scan (computerized axial tomography); and magnetic resonance imaging (“MRI”) procedures rendered and billed by a Professional Provider.

The Program will provide coverage for a CAT scan or for any other radiation imagery procedure if it is performed by a Professional Provider in a Facility and the installation of the equipment required for the CAT scan or other procedure has been approved by law. If the CAT scan or other procedure is performed in New York State, the installation of the equipment must have been approved under the New York State Public Health Law. If it is performed outside New York State, the installation of the equipment must have the approval of a comparable state authority. If the CAT scan or other procedure is performed in a Professional Provider's office, the Program will provide the CAT scan or other procedure only if the New York State Public Health Law provides an approval

procedure for such a location and only if the installation of the equipment where you receive the service has been approved under that procedure.

**Basic Benefit.** Covered in full.

10. **Radiation Therapy and Chemotherapy.** The Program will provide coverage for radiation therapy and chemotherapy.

**Basic Benefit.** Covered in full.

11. **Hemodialysis.** The Program will provide coverage for hemodialysis treatments of an acute or chronic kidney ailment.

**Basic Benefit.** Covered in full.

12. **Mammography Screenings.** The Program will provide coverage, subject to the limitations stated below, for mammography screenings for occult breast cancer. The screenings may be provided in a Professional Provider's office under this Section or in the outpatient department of a Facility pursuant to Section Six, Paragraph 6. The Program's coverage for routine mammography screenings under this Section and Section Six, Paragraph 6 is subject to the following aggregate limitations:

- A. **Women at Risk.** The Program will provide coverage for mammograms for women of any age who have a prior history of breast cancer or who have a first degree relative (such as a child, mother or sister), or a paternal or maternal grandmother who has a prior history of breast cancer, if the mammogram is recommended by a physician.
- B. **Women 35 Through 39 Years of Age.** The Program will provide coverage for one baseline mammogram for women 35 through 39 years of age.
- C. **Women 40 Years of Age And Older.** The Program will provide coverage for one mammogram in each Calendar Year for women 40 years of age and older.

Mammography screening shall mean an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose of less than 0.5 rem per view per breast.

**Basic Benefit.** Routine mammography screenings are covered in full.

13. **Gynecological Services.** The Program will provide coverage for diagnostic gynecology visits. The screenings may be provided in the outpatient department of a Facility pursuant to Section Six, Paragraph 7 or in a Professional Provider's office pursuant to this Section.

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

14. **Screenings For Prostate Cancer.** The Program will provide coverage for In-Network diagnostic screenings for prostate cancer when prescribed by a health care practitioner legally authorized to prescribe under Title 8 of the New York Education Law. Coverage for prostate screenings shall be subject to the following limitations:
- A. **Men with a Prior History of Prostate Cancer.** The Program will provide coverage for standard diagnostic testing for men of any age who have had a prior history of prostate cancer.
  - B. **Men at Risk.** The Program will provide coverage for one standard diagnostic exam in each Calendar Year for men over the age of 40 who have a family history of prostate cancer or who have other risk factors for prostate cancer.
  - C. **Men 40 Years of Age or Older.** The Program will provide coverage for one standard diagnostic exam in each Calendar Year for men 40 years of age and older.

A standard diagnostic exam includes, but is not limited to, a digital rectal exam and a prostate specific antigen (PSA) test.

**Basic Benefit.** Covered in full.

15. **Allergy Testing and Treatment.** Allergy testing includes injections and tests to determine the nature of allergies. Allergy treatment includes desensitization treatments to alleviate allergies, including test or treatment materials.

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

16. **Chiropractic Care.** The Program will provide coverage, in accordance with Excellus BCBS Medical Policy Guidelines, for Medically Necessary services rendered in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column. However, such services must be:
- A. Rendered by a provider licensed to provide such services; and
  - B. Determined to be Medically Necessary.

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

17. **Acupuncture.** The Program will provide coverage for Medically Necessary service or care related to acupuncture treatment and acupuncture therapy for up to a limit of 10 visits per covered person per Calendar Year

**Major Medical Benefit.** Benefits are covered at 80% of the Allowable Expense, after Deductible.

18. **Inpatient Consultations.** The Program will provide coverage for consultations billed by a physician subject to the limitations below. A consultation is professional advice given by a physician to your attending physician upon request of your attending physician.

- A. The physician who is called in is a specialist in your illness or disease;
- B. The consultations take place while you are a registered bed patient in a Facility;
- C. The consultation is not required by the rules or regulations of the Facility;
- D. The consulting physician does not thereafter render care or treatment to you;
- E. The consulting physician enters a written report in your Facility records; and
- F. Payment will be made for only one consultation during any one day unless a separate diagnosis exists.

**Basic Benefit.** Covered in full.

19. **Elective Sterilization.** The Program will provide benefits for services in connection with elective sterilization, even if the elective sterilization is not Medically Necessary. Services in connection with the reversal of elective sterilization are never covered.

- A. The Program will provide coverage for Medically Necessary inpatient care in connection with elective sterilization in accordance with the inpatient care benefit described in Section 5.
- B. The Program will provide coverage for Medically Necessary outpatient care in connection with elective sterilization in accordance with the outpatient care benefit described in Section 6.

20. **Bone Density Testing.** The Program will cover bone mineral density measurements and tests for the detection of osteoporosis. The Program will apply standards and guidelines that are consistent with the criteria of the federal Medicare program or the National Institutes of Health (“NIH”) to determine appropriate coverage for bone density testing under this Paragraph. Coverage will be provided for tests covered under Medicare or consistent with the NIH criteria including, as consistent with such criteria, dual-energy

x-ray absorptiometry. When consistent with the Medicare or NIH criteria coverage, at a minimum, will be provided for those Members.

- A. Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- B. With symptoms or conditions indicative of the presence, or a significant risk, or osteoporosis; or
- C. On a prescribed drug regimen posing a significant risk of osteoporosis; or
- D. With lifestyle factors to the degree of posing a significant risk of osteoporosis; or
- E. With such age, gender, and/or physiological characteristics that pose a significant risk or osteoporosis.

**Basic Benefit.** Covered in full

**Major Medical Benefit.** Covered in full, less any Medicare payment.

21. **Acupuncture.** The Program will provide coverage for Medically Necessary service or care related to acupuncture treatment and acupuncture therapy for up to a limit of 10 visits per Member per Calendar Year.

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

22. **Colorectal Screenings.** The Program provides coverage for routine colorectal screening exams for a flexible sigmoidoscopy one time every 5 years and a colonoscopy every 10 years.

**Basic Benefit.** Covered in full

**Major Medical Benefit.** Covered in full, less any Medicare payments.



## SECTION TEN - ADDITIONAL BENEFITS

1. **Treatment Of Diabetes.** The Program will provide coverage for the following equipment and supplies for the treatment of diabetes when it is determined to be Medically Necessary and when prescribed or recommended by your Professional Provider or other medical personnel legally authorized to prescribe under Title 8 of the New York State Education Law (“Authorized Medical Personnel”):

- Insulin and oral agents for controlling blood sugar limited to a 30-day supply when purchased at a retail pharmacy, or a 90-day supply when purchased at a mail order pharmacy;
- Blood glucose monitors;
- Blood glucose monitors for the legally blind;
- Data management systems;
- Test strips for glucose monitors, visual reading, and urine testing;
- Injection aids;
- Cartridges for the legally blind;
- Insulin pumps and appurtenances thereto;
- Insulin infusion devices; and
- Additional Medically Necessary equipment and supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

Repair, replacement and adjustment of the above diabetic equipment and supplies are covered when made necessary by normal wear and tear. Repair and replacement of diabetic equipment and supplies made necessary because of loss or damage caused by misuse or mistreatment are not covered.

The Program will also pay for disposable syringes and needles used solely for the injection of insulin. The Program will not pay for reusable syringes and needles or multi-use disposable syringes or needles.

The Program will pay for diabetes self-management education and diet information provided by your Professional Provider or other authorized medical personnel, or their staff, in connection with Medically Necessary visits upon the diagnosis of diabetes, a significant change in your symptoms, the onset of a condition necessitating changes in self-management, or where re-education or refresher education is Medically Necessary, as determined by Excellus BlueCross BlueShield. When such education is provided as part of the same office visit for diagnosis or treatment of diabetes, payment for the office visit shall include payment for the education. The Program will also pay for home visits, when Medically Necessary.

Education is also covered when provided by the following medical personnel upon a referral from your Professional Provider or Authorized Medical Personnel: certified diabetes nurse educator, certified nutritionist, certified dietician, registered dietician, or

other provider as required by law applicable to insured health benefits contracts. Such education must be provided in a group setting, when practicable.

**Major Medical Benefit.** Diabetic education is covered at 80% of the Allowable Expense, after Deductible.

**Major Medical Benefit.** Benefits for diabetic supplies and insulin obtained through a retail provider are covered at 80% of the Allowable Expense, after Deductible for a 30-day supply. Benefits for diabetic supplies and insulin purchased by mail order are covered at 80% of the Allowable Expense, after Deductible for a 90-day supply. Benefits for diabetic durable medical equipment is covered at 80% of the Allowable Expense, after Deductible.

2. **Durable Medical Equipment.** The Program will provide coverage for the rental, purchase, repair, or maintenance of durable medical equipment. The Program will provide coverage for durable medical equipment that your physician or other licensed/authorized provider and the Medical Director determine to be Medically Necessary. The equipment must be the kind that is generally used for a medical purpose, as opposed to a comfort or convenience purpose. Excellus BlueCross BlueShield will determine whether the item should be purchased or rented.

Durable medical equipment is equipment that can withstand repeated use, can normally be rented and reused by successive patients, is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a person's home. Examples of covered equipment include, but are not limited to: crutches, wheelchairs (the Program will not pay for motor-driven wheelchairs unless Medically Necessary), a special hospital type bed, or a home dialysis unit. Examples of equipment the Program will not cover include, but are not limited to: air conditioners, humidifiers, dehumidifiers, air purifiers, sauna baths, exercise equipment, or medical supplies.

No coverage is provided for the cost of rental, purchase, repair, or maintenance of durable medical equipment covered under warranty or the cost of rental, purchase, repair, or maintenance due to misuse, loss, natural disaster, or theft, unless approved in advance by the Medical Director. No coverage is provided for the additional cost of deluxe equipment. The Program will not provide coverage for delivery or service charges, or for routine maintenance.

**Major Medical Benefit.** Covered in full. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

3. **External Prosthetic Devices.** The Program will provide coverage for external prosthetic devices and their replacements necessary to relieve or correct a condition caused by an injury or illness. Your physician must order the prosthetic device for your condition before its purchase. Although the Program requires that a physician prescribe the device, this does not mean that it will automatically be determined that you need it. Excellus

BlueCross BlueShield will determine if the prosthetic device is Medically Necessary. The Program will only provide benefits for prosthetic devices that can adequately meet the needs of your condition at the least cost.

A prosthetic device is an artificial organ or body part, including, but not limited to, artificial limbs and eyes. Prosthetic devices include, for example: artificial arms, legs, and eyes used to replace functioning natural body parts; ostomy bags and supplies required for their use; and catheters. Prosthetic devices do not include, for example: hearing aids; eyeglasses; contact lenses; medical supplies; wigs; or foot orthotics such as arch supports or insoles, regardless of the Medical Necessity of those items. Dentures or other devices used in connection with the teeth are also not covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. The Program will provide benefits for contact lenses when they perform the function of the human lens and are Medically Necessary because of intra-ocular surgery.

Not included in this benefit are: the cost of rental, purchase, repair, or maintenance of prosthetic devices because of misuse, loss, natural disaster, or theft or the cost of deluxe items, unless approved in advance by the Medical Director. The Program will not provide coverage for delivery or service charges, or for routine maintenance related to prosthetic devices.

**Major Medical Benefit.** Covered in full, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

4. **Orthotic Devices.** The Program will provide coverage for orthotic devices that are rigid or semi-rigid (having molded plastic or metal stays) and their replacements when the devices are necessary to: support, restore, or protect body function; redirect, eliminate, or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness. Orthotic devices include orthopedic braces and custom-built supports. Your physician must order the orthotic device for your condition before its purchase. Although the Program requires that a physician prescribe the device, this does not mean that it will automatically be determined that you need it. Excellus BlueCross BlueShield alone will determine if the orthotic device is Medically Necessary. The Program will only provide benefits for an orthotic device that can adequately meet the needs of your condition at the least cost.

**Major Medical Benefit.** Covered in full, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

5. **Medical Supplies.** The Program will provide coverage for disposable medical supplies when you are not an inpatient in a Facility and it is determined that a large quantity is necessary for the treatment of conditions such as cancer, diabetic ulcers, surgical wounds, and burns. Disposable medical supplies; are used to treat conditions caused by injury or illness; do not withstand repeated use (cannot be used by more than one

patient); and are discarded when their usefulness is exhausted. Examples of disposable medical supplies include: bandages; surgical gloves, tracheotomy supplies; and compression stockings.

Not included in this benefit are: supplies that are considered to be purchase primarily for comfort or convenience; delivery and/or handling charges.

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

6. **Ambulance Service.** The Program will provide coverage for Medically Necessary ground, water or air ambulance service provided by a Hospital, professional, or licensed ambulance service for a life-threatening or urgent condition. The ambulance must transport you to the nearest Facility for an inpatient admission or emergency outpatient care. If the nearest Facility cannot treat your disability or condition, the Program will provide coverage for ambulance service to the nearest Facility that can render the treatment you need. Medically Necessary transportation between Facilities is covered.

**Pre-hospital Emergency Services and Transportation.** The Program will provide coverage for services to evaluate and treat an “emergency condition” as that term is defined in the Emergency Care Section of this Booklet when such services are provided by an ambulance service certified under the Public Health Law. The Program also will provide coverage for land ambulance transportation to a Hospital by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- A. Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- B. Serious impairment to such person’s bodily functions;
- C. Serious dysfunction of any bodily organ or part of such person; or
- D. Serious disfigurement of such person.

**Basic Benefit.** Covered in full.

## SECTION ELEVEN - EMERGENCY CARE

The emergency care benefits described in this Section apply both when you are within the Service Area and when you are traveling or visiting outside of the Service Area.

1. **Emergency Conditions.** An Emergency Condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
  - A. Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or
  - B. Serious impairment to such person's bodily functions;
  - C. Serious dysfunction of any bodily organ or part of such person; or
  - D. Serious disfigurement of such person.

Examples of medical conditions that are considered to be Emergency Conditions are heart attacks, poisoning, and multiple trauma.

Examples of conditions that are not ordinarily considered to be Emergency Conditions are head colds, flu, minor cuts and bruises, muscle strain, and hemorrhoids.

2. **Eligibility For Benefits.** The Program will provide coverage for care at the emergency room if your illness or condition is considered an Emergency Condition. The Program will provide coverage for medical visits of Professional Providers who are not Facility employees or interns to treat an Emergency Condition in an emergency room.

When you make visits to the emergency room for a condition that is not an Emergency Condition as defined above, you will be liable for the entire charge for the visit including all associated charges such as, but not limited to, x-ray, laboratory services, and medication expenses.

3. **Payment For Emergency Care In A Hospital Emergency Room.**

**Basic Benefit.** Covered in full.

4. **Payment For Emergency Care In A Free Standing Urgent Care Center.** The Program will provide coverage for care in a Free Standing Urgent Care Center if your illness or condition is considered an Emergency Condition.

**Major Medical Benefit.** Covered at 80% of the Allowable Expense, after Deductible.

5. **Payment For A Professional Provider's Hospital Emergency Room Visit.** The Program will provide coverage for visits of Professional Providers if your illness or condition is considered an Emergency Condition. The Program will not provide coverage for medical visits by Facility employees or interns, even if they are Professional Providers.

**Basic Benefit.** Covered in full.

## **SECTION TWELVE - HUMAN ORGAN AND BONE MARROW TRANSPLANTS**

The Program will provide coverage for all of the benefits otherwise covered under this Program for organ and bone marrow transplants subject to the following limits:

- 1. Prior Approval Required.** All organ transplants must be pre-approved by Excellus BlueCross BlueShield. See Section Three for the Program's pre-approval procedures. You or your Professional Provider must call Excellus BlueCross BlueShield within one week prior to admission to seek approval. In the event of the availability of an organ for transplantation resulting in the necessity for an immediate admission for implantation, you must call Excellus BlueCross BlueShield within 24 hours after your admission or as soon thereafter as reasonably possible. If you fail to seek Excellus BlueCross BlueShield's prior approval for an organ transplant, the Program will provide coverage for an amount \$500 less than the Program would otherwise cover for the care, or the Program will provide coverage for only 50% of the amount the Program would otherwise have covered for the care, whichever results in a greater benefit to you. You must pay the remaining charges. The Program will provide coverage for the amount specified above only if it is determined the care was Medically Necessary, even though you did not seek Excellus BlueCross BlueShield's prior approval. If it is determined that the services were not Medically Necessary, you will be responsible for paying the entire charge for the service.
- 2. Care In Approved Transplant Centers.** Certain types of organ transplant procedures must be performed in In-Network transplant centers approved by Excellus BlueCross BlueShield for the specific transplant procedure being performed. The types of organ transplants which must be performed in an In-Network transplant center are bone marrow transplants, liver transplants, heart transplants, lung transplants, heart-lung transplants, kidney transplants, and kidney-pancreas transplants. You may contact Excellus BlueCross BlueShield if you wish to obtain a list of approved transplant centers.
- 3. No Coverage Of Experimental Or Investigational Organ Transplants.** The Program will not provide coverage for any benefits for an organ transplant that is determined to be experimental or investigational. Excellus BlueCross BlueShield maintains and revises from time to time a list of organ transplant procedures which it determines not to be experimental or investigational, and, therefore, may be covered under the Program. You may contact Excellus BlueCross BlueShield if you have a question concerning whether a particular transplant procedure may be covered.
- 4. Recipient Benefits.** The Program will provide coverage for a person covered under this Program for all of the benefits provided to the recipient of the organ transplant that are otherwise covered under the Program when they result from or are directly related to a covered organ or bone marrow transplant.
- 5. Coverage For Donor Searches Or Screenings.** The Program will not provide coverage for costs relating to searches or screenings for donors of organs.

6. **Costs Of Organ Donor.** The Program will provide coverage for the medical services directly related to the donation of an organ for transplantation to a person covered under the Program. The Program will not provide coverage if you are donating an organ for transplantation to a person not covered under this Program.

**Basic Benefit.** Covered in full.



## SECTION THIRTEEN – PRESCRIPTION DRUG BENEFITS

1. **Definitions.** For the purposes of this section, the following definitions shall apply:
  - A. **Brand Name Drug.** A Prescription Drug that is manufactured; approved and marketed under a New Drug Application (NDA).
  - B. **Generic Drug.** A Prescription Drug that is manufactured, approved, and marketed under an Abbreviated New Drug Application (ANDA).
  - C. **Negotiated Rate.** The rate of payment agreed to between the Participating Pharmacy and Excellus BlueCross BlueShield for Prescription Drugs covered under this Program.
  - D. **Non-Participating Pharmacy.** Any pharmacy that dispenses Prescription Drugs and has not entered into a participation agreement with Excellus BlueCross BlueShield. **No benefits will be provided for Prescription Drugs you purchased at a Non-Participating Pharmacy.**
  - E. **Participating Pharmacy.** Any pharmacy that regularly dispenses Prescription Drugs and has entered into a participation agreement with Excellus BlueCross BlueShield.
  - F. **Prescription Drug(s).** Drugs, biologicals and compounded prescriptions that can be dispensed only pursuant to a prescription and that are required by law to bear the legend “Caution - Federal Law prohibits dispensing without a prescription”, or that are specifically designated by Excellus BlueCross BlueShield. The drug or medication must be prescribed by a provider authorized to prescribe, and approved by the FDA as a drug for the treatment of your specific diagnosis or condition. The drug must also be approved by Excellus BlueCross BlueShield as Medically Necessary treatment of the condition for which the drug is prescribed. In certain situations, specific criteria, including Medical Necessity criteria, may be established by Excellus BlueCross BlueShield and its local provider community, defining whether certain drugs will be covered under this Program. However, if there is a drug that has been approved for the treatment of one type of cancer, Excellus BlueCross BlueShield will also pay for this drug for the treatment of other types of cancer, so long as the drug meets the requirements of Excellus BlueCross BlueShield’s guidelines.

Prescription Drugs shall include Medically Necessary enteral formulas, administered orally or via tube feeding, for which an authorized provider has issued a written order. The written order must state that the enteral formula is clearly Medically Necessary and has been proven effective as a disease-specific method of treatment for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated. Excellus BlueCross BlueShield will also

pay for modified solid food products for the treatment of certain inherited diseases of amino acid or organic acid metabolism, when provided pursuant to such written order. The tier designation(s) that apply to modified solid food products are identified on the formulary that is available at the following website at [www.excellusbcbcs.com](http://www.excellusbcbcs.com), or that will be mailed to you upon request. You may request the formulary by calling the number shown on your ID card.

Prescription Drugs include drugs and devices, or their generic equivalents, approved by the FDA for treatment of osteoporosis. Excellus BlueCross BlueShield will apply standards and guidelines that are consistent with the criteria of the federal Medicare program or the National Institutes of Health (“NIH”) to determine appropriate coverage for treatment of osteoporosis under the Program. Benefits will be provided for drugs and devices covered under Medicare or consistent with the NIH criteria. When consistent with the Medicare or NIH criteria, coverage, at a minimum, will be provided for those Members:

- (1) Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- (2) With symptoms or conditions indicative of the presence, or a significant risk, of osteoporosis; or
- (3) On a prescribed drug regimen posing a significant risk of osteoporosis; or
- (4) With lifestyle factors to the degree of posing a significant risk of osteoporosis; or
- (5) With such age, gender and/or physiological characteristics that pose a significant risk of osteoporosis.

## 2. **Pharmacy Benefits Provided.**

Once you have satisfied the Deductible, Prescription Drugs are available from a Participating retail pharmacy as follows:

- A. If you have a prescription filled with a Generic Drug, you must pay the pharmacy 20% Coinsurance for the cost of the Generic Drug. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or refill. The Deductible is waived for diabetic supplies.
- B. If you have a prescription filled with a Brand Name Drug, you must pay the pharmacy 20% Coinsurance for the cost of the Brand Name Drug. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or refill. The Deductible is waived for diabetic supplies.

If you have a Prescription Drug filled with a Brand Name Drug and there is a therapeutic equivalent Generic Drug available for that Brand Name Drug the Payment under the Program will be based on the therapeutic equivalent Generic Drug

Negotiated Rate or the Participating Pharmacy's charge for the Generic Drug, whichever is less. You will be responsible for the Brand Name Drug Coinsurance set forth above and the difference in cost between the payment under the Program and the actual cost of the Brand Name Drug.

For example, assume you have a prescription for a Brand Name Drug that costs \$100, and the therapeutic equivalent Generic Drug has a Negotiated Rate of \$25. The Program will pay the \$25, less the applicable Coinsurance amount. You must pay the Brand Name Drug Coinsurance plus the \$75 balance remaining on the \$100 cost.

- C. The Program will not pay any benefits for drugs that you purchase at a Non-Participating Pharmacy.
- D. **Cost-Sharing for Orally-Administered Anticancer Medications.** Your cost-sharing for orally-administered anticancer medications covered under this Program is the lesser of: the amount described in Subparagraph (1) or (2) above; or the cost-sharing amount, if any, that applies to anticancer medications that are administered intravenously or by injection, and are covered as a medical benefit under the Program.
- E. **Generic Trial Program.** You are able to fill a Generic Drug otherwise covered under this Program at no cost, after you have satisfied the Deductible, for six months from the date of the first fill of the Generic Drug, so long as the medication is included in Excellus BlueCross BlueShield's Generic Trial Program and you fill the prescription at a Participating retail or mail order Pharmacy. Only one free trial is permitted per member per medication.

### 3. **Limitations.**

#### A. **Prior Authorization; Step Therapy Program.**

- (1) **Prior Authorization.** Certain Prescription Drugs will only be filled with prior authorization from Excellus BlueCross BlueShield. The Prescription Drugs that require prior authorization are identified based upon cost, patient safety, and possible use for purposes that are not Medically Necessary or appropriate. The Prescription Drugs that require prior authorization are included on the form entitled "Prescription Drugs Requiring Prior Authorization" that is given to you with this Program. The Prescription Drugs that require prior authorization are also identified on the formulary that is available at [www.excellusbcbs.com](http://www.excellusbcbs.com) or that will be mailed to you upon request. You may request the formulary by calling the number shown on your ID card. The Prescription Drugs that require prior authorization may change as described in Subparagraphs (3) and (4) below. You are encouraged to call Excellus BlueCross BlueShield or consult the formulary to determine if prior authorization is required for a specific drug so that you can avoid any benefit reduction that will apply if you fail to comply with the prior authorization requirement.

- (a) **Prior Authorization Procedure.** To obtain prior authorization you (or your designee) or your Professional Provider must call the number on your ID card; and your provider must submit a statement of Medical Necessity to Excellus BlueCross BlueShield. After receiving a request for prior authorization, the statement of Medical Necessity will be reviewed and a determination will be made as to whether or not benefits are available under the Program. You (or your designee) and your Professional Provider will be notified of the Program's determination by telephone and in writing within three business days of receipt of all necessary information.

With respect to an urgent request for prior authorization, if the Program has all information necessary to make a determination, a determination will be made and you (or your designee) and your Professional Provider will be notified, by telephone and in writing, within 72 hours of receipt of the request. If additional information is needed to make a determination, the Program will request the information within 24 hours after receipt of your request. You or your provider will then have 48 hours to submit the information. A determination will be made and notice will be provided to you and your provider by telephone and in writing within 48 hours of the earlier of receipt of the additional information or the end of the 48-hour period. A request is "urgent" if failing to receive the service it could seriously jeopardize your life or health or the ability to regain maximum function; or if your provider determines that receipt of the service is urgent.

- (b) **Your Right to Appeal.** If you (or your designee) or your Professional Provider disagrees with the Program's determination, you may appeal by following the appeal procedures set forth in Section Eighteen of this Program.
- (c) **Failure to Seek Authorization.** When you fail to seek a required prior authorization of a Prescription Drug and the drug is dispensed, you must pay the Participating Pharmacy the total cost of the drug. If you then submit a claim, and Excellus BlueCross BlueShield determines that the Prescription Drug is Medically Necessary, the Program will pay only 50% of the amount it would otherwise have paid for the Prescription Drug. If Excellus BlueCross BlueShield determines that the Prescription Drug is not Medically Necessary, no benefits will be provided for the Prescription Drug and you will be responsible for the entire charge.

- (2) **Step Therapy Program.** The Step Therapy Program is a form of prior

authorization under which certain Prescription Drugs require prior authorization if a Generic Drug or cost-effective alternative Prescription Drug has not been tried. The Prescription Drugs that require prior authorization under the Step Therapy Program are also included on the form entitled “Prescription Drugs Requiring Prior Authorization” that is given to you with this Program. In addition, these Prescription Drugs are identified on the formulary that is available at [www.excellusbcbs.com](http://www.excellusbcbs.com) or that will be mailed to you upon request. You may request the formulary by calling the number shown on your ID card.

- (3) **Prescription Drugs that Receive FDA Approval.** Prior authorization or step therapy applies to all new drugs entering the market upon FDA approval. The new drugs will be added to the Prior Authorization and Step Therapy Drug List until Excellus BlueCross BlueShield determines that the new drug satisfies the criteria for safety, efficacy and cost-effectiveness.
- (4) **Other Changes.** The Program may added or changed on a Brand Name Drug when a therapeutically equivalent Generic Drug becomes available; or to promote safe utilization of a Prescription Drug based on new clinical guidelines or information related to drug safety and effectiveness. These changes will be made following notice to affected Members.

- B. The Program will pay for no more than a 90-day supply of a Prescription Drug purchased at a retail Participating Pharmacy or a 90-day supply dispensed by a mail order Participating Pharmacy, except for diabetic supplies. The Program will pay for no more than a 30-day supply of diabetic supplies purchased from a retail Participating Pharmacy or a 90-day supply purchased by a mail order Participating Pharmacy.

Participating Pharmacies include:

Strong Memorial Hospital Outpatient Pharmacy, 601 Elmwood Avenue, Rochester NY (NAPB 3357731); and

Strong Ties Outpatient Pharmacy, 2613 W. Henrietta Road, Rochester, NY (NAPB 3347639).

- C. The Program will pay for no more than 6 tablets per month for Viagra.
- D. Covered quantities, day supply, early refill access, and/or duration of therapy may be limited for certain medications based on acceptable medical standards and/or FDA recommended guidelines.

Benefits will be provided for drug refills. However, no benefit will be provided for a refill obtained before the date that you should have exhausted most of your

current supply. Benefits for refills will not be provided beyond one year from the original prescription date.

**Early Refills of Prescription Eye Drops.** Notwithstanding anything to the contrary set forth above in this Subparagraph C, the Program will provide coverage for a limited refill of prescription eye drops prior to the last day of the dosage period. To the extent practicable, the quantity of eye drops in the early refill will be limited to the amount remaining on the dosage that was initially dispensed. Your cost-sharing for the limited refill is the amount that applies to each prescription or refill as set forth in Subparagraph 2.A above.

- E. Compounded Prescription Drugs will be covered only when they contain at least one ingredient that is a covered legend Prescription Drug, are Medically Necessary, and are obtained from a Participating Pharmacy that is approved for compounding. All compounded Prescription Drugs require prior authorization.
  - F. Excellus BlueCross BlueShield may periodically identify over-the-counter non-prescription drugs that will be covered in place of the Prescription Drug equivalent. If an over-the-counter non-prescription drug will be covered in place of a Prescription Drug, Excellus BlueCross BlueShield will notify you in writing in advance and will specify whether the Copayment for the non-prescription drug will be based on the Tier One, Tier Two, or Tier Three Copayment. A list of over-the-counter drugs that will be covered in place of Prescription Drugs can be obtained from Excellus BlueCross BlueShield's office.
  - G. A pharmacy will not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.
  - H. Various specific and/or generalized "use management" protocols will be used from time-to-time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Members with a quality-focused drug benefit. In the event a use management protocol is implemented, and you are taking the drug(s) affected by the protocol, you will be notified in advance.
4. **Exclusions.** Benefits will not be provided for the following:
- A. Drugs that do not by law require a prescription, except as otherwise provided in this Program.
  - B. Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name as their prescription counterparts. This exclusion does not apply to any over-the-counter drug, that is required to be covered as a preventive service in accordance with Section Ten, Subparagraph 9 or that is otherwise provided under Subparagraph 3(F) above.

- C. Devices of any type, even though a prescription may be required, except for devices for treatment of osteoporosis as provided in Subparagraph 1(F) or contraceptive devices that are required to be covered as a preventive service in accordance with Section Ten, Subparagraph 9. This includes therapeutic devices, artificial appliances, hypodermic needles or similar devices.
- D. Vitamins, or any herbal product, except those that require a prescription by law and have been approved by the FDA under the NDA or ANDA process.
- E. Drugs that are prescribed or dispensed for cosmetic purposes and are not Medically Necessary. Examples of the kinds of drugs that Excellus BlueCross BlueShield determines not Medically Necessary include those prescribed or dispensed for hair growth or removing wrinkles.
- F. Drugs dispensed in unit-dose packaging when bulk packaging is available.
- G. Drugs given or administered in a physician's office or in an inpatient or outpatient facility, unless otherwise covered elsewhere in the Program.
- H. Administration or injection of any drugs, unless otherwise covered elsewhere in the Program.
- I. Drugs dispensed to a Member while a patient in a hospital, nursing home, other institution, or a home care patient, except in those cases where the basis of payment by or on behalf of the Member to the hospital, nursing home, home health agency or home care services agency, or other institution, does not include services for drugs.
- J. Your benefit for diabetic supplies and equipment is not provided under this Section. Diabetic supplies and equipment, including blood glucose monitors, insulin, test strips, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for controlling blood sugar, are included, along with the applicable Copayment, Deductible, and/or Coinsurance Charges that are set forth in Section Ten of this Program.
- K. Fertility drugs relating to reversal of elective sterilizations, including vasectomies and tubal ligations; sex change procedures; cloning; and other procedures or categories of procedures excluded by statute as applicable to insured health benefit contracts.

**5. General Conditions.**

- A. You must present your identification card to a Participating retail Pharmacy and include your identification number on the forms provided by the Participating mail order Pharmacy from which you make a purchase.

- B. Drug Utilization, Cost Management and Rebates. The Program conducts various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, the Group and its Members benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the cost of your coverage. From time-to-time, the Program may receive rebates or other funds (“rebates”) directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drug products under the Program. Any rebates received by the Program may or may not be applied, in whole or part, to reduce costs of the Program either through an adjustment to claims costs or as an adjustment to the administrative expenses of the Program. Instead, any such rebates may be retained by the Program, at its discretion, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment, Coinsurance or Deductibles applicable under our Prescription Drug coverage.
  
- D. Neither Excellus BlueCross BlueShield or the Program will be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of merchantability), arising out of or in connection with the sale, compounding, dispensing, manufacturing or use of any Prescription Drug whether or not covered under this Program.
  
- E. Benefits may be denied for any Prescription Drug prescribed or dispensed in a manner contrary to normal medical practice.



## SECTION FOURTEEN – EXCLUSIONS

In addition to the exclusions and limitations described in other Sections of this Booklet, **the Program will not provide coverage for any service or care that is not specifically described in this Booklet as a covered service; or that is related to service or care not covered under this Program.** The Program will also not provide coverage for the following:

1. **Blood Products.** The Program will not provide coverage for the cost of blood, blood plasma, other blood products, or blood processing or storage charges.
2. **Certification Examinations.** The Program will not provide coverage for any service or care related to a routine physical examination and/or testing to certify health status, including, but not limited to, an examination required for school, employment, insurance, marriage, licensing, travel, camp, sport, or adoption.
3. **Cosmetic Services.** The Program will not provide coverage for any services in connection with elective cosmetic surgery that is primarily intended to improve your appearance and is not Medically Necessary. Examples of the kinds of services that are often determined to be not Medically Necessary include, but are not limited to, the following: breast reduction or enlargement, rhinoplasty, and hair transplants. The Program will, however, provide coverage for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other disease of the part of the body involved. The Program also will provide coverage for reconstructive surgery because of congenital disease or anomaly of a child covered under this Program that has resulted in a functional defect. The Program also will provide coverage for services in connection with reconstructive surgery following a mastectomy.
4. **Court-Ordered Services.** The Program will not provide coverage for any service or care (including evaluation, testing, and/or treatment) that is ordered by a court, or that is required by a court as a condition of parole or probation, unless:
  - A. The service or care would be covered under this Program in the absence of a court order;
  - B. The service or care has been pre-authorized by the Program, if required; and
  - C. It is determined, in advance, that the service or care is Medically Necessary and covered under the terms of this Program.

This exclusion applies to special medical reports, including those not directly related to treatment, e.g., reports on certification examinations and reports prepared in connection with litigation.

5. **Criminal Behavior.** The Program will not provide coverage for any service or care related to the treatment of an illness, accident, or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred.
6. **Custodial Care.** The Program will not provide coverage for any service or care that is custodial in nature, or any therapy that is reasonably determined to not be expected to improve your condition. Care is considered custodial when it is primarily for the purpose of meeting personal needs and includes activities of daily living such as help in transferring, bathing, dressing, eating, toileting, and such other related activities.
7. **Dental Care.** The Program will not provide coverage for any service or care (including anesthesia and inpatient stays) for treatment of the teeth, gums, or structures supporting the teeth, or any form of dental surgery, regardless of the reason(s) that the service or care is necessary. For example, the Program will not provide coverage for x-rays, fillings, extractions, braces, prosthetics, correction of impactions, treatments for gum disease, therapy, or other treatments related to dental oral surgery. The Program will, however, provide coverage for medical treatment that is directly related to an injury or accident involving the jaw or other bone structures adjoining the teeth, provided that the treatment is approved by the Medical Director. The Program will provide the benefits set forth in this Booklet for service and care for treatment of sound natural teeth provided within twelve (12) months of an accidental injury. The Program does not consider an injury to a tooth caused by chewing or biting to be an accidental injury.
8. **Experimental And Investigational Services.** Unless otherwise required by law, the Program will not provide coverage for any service or care that consists of a treatment, procedure, drug, biological product, or medical device (collectively, "Service"); an inpatient stay in connection with a Service; or treatment of a complication related to a Service; if, Excellus BlueCross BlueShield determines the Service is experimental or investigational.

"Experimental or investigational" means that it is determined that the Service is:

- A. Not of proven benefit for a particular diagnosis or for treatment of a particular condition;
- B. Not generally recognized by the medical community, as reflected in published, peer-reviewed, medical literature, as effective or appropriate for a particular diagnosis or for treatment of a particular condition; or
- C. Not of proven safety for a person with a particular diagnosis or a particular condition, i.e., is currently being evaluated in research studies to ascertain the

safety and effectiveness of the treatment on the well-being of a person with the particular diagnosis or in the particular condition.

Governmental approval of a Service will be considered in determining whether a Service is experimental or investigational, but the fact that a Service has received governmental approval does not necessarily mean that it is of proven benefit, or appropriate or effective treatment for a particular diagnosis or for a particular condition.

In determining whether a Service is experimental or investigational, Excellus BlueCross BlueShield may, in its discretion, require that any or all of the following five criteria be met:

- A. A Service that is a medical device, drug, or biological product must have received final approval of the United States Food and Drug Administration (FDA) to market for the particular diagnosis or for your particular condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once final FDA approval has been granted for a particular diagnosis or for your particular condition, use of the Service (medical device, drug, or biological product) for another diagnosis or condition may require that any or all of the five criteria be met.
- B. Published, peer-reviewed, medical literature must provide conclusive evidence that the Service has a definite, positive effect on health outcomes. The evidence must include reports of well-designed investigations that have been reproduced by nonaffiliated, authoritative sources with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.
- C. Published, peer-reviewed, medical literature must provide demonstrated evidence that, over time, the Service leads to improvement in health outcomes, i.e., the beneficial effects of the Service outweigh any harmful effects.
- D. Published, peer-reviewed, medical literature must provide proof that the Service is at least as effective in improving health outcomes as established services or technology, or is usable in appropriate clinical contexts in which an established service or technology is not employable.
- E. Published, peer-reviewed, medical literature must provide proof that improvement in health outcomes, as defined in Subparagraph C above, is possible in standard conditions of medical practice, outside of clinical investigatory settings.

This exclusion shall not limit in any way benefits available for prescription drugs otherwise covered under this Program which have been approved by the FDA for the treatment of certain types of cancer, when those drugs are prescribed for the treatment of a type of cancer for which they have not been approved by the FDA, so long as the drugs so prescribed meet the requirements of Section 4303(q) of the New York Insurance Law (as applicable to insured health benefits contracts).

9. **Free Care.** The Program will not provide coverage for any service or care that is furnished to you without charge, or that would have been furnished to you without charge if you were not covered under this Program. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your spouse, brother, sister, mother, father, son or daughter; or the spouse of any of them; it will be presumed that the service or care would have been furnished without charge. You must prove that a service or care would not have been furnished without charge.
  
10. **Government Hospitals.** Except as otherwise required by law, the Program will not provide coverage for any service or care you receive in a Facility or institution which is owned, operated or maintained by the Veterans Administration, or by a federal, state, or local government, unless the Facility is an In-Network Provider. However, the Program will provide coverage for services or care in such a Facility to treat an Emergency Condition. In this case, the Program will continue to provide coverage only for as long as emergency care is necessary and it is not possible for you to be transferred to another Facility.
  
11. **Government Programs.** The Program will not provide coverage for any service or care for which benefits are payable under Medicare or any other federal, state, or local government program, except when required by state or federal law. When you are eligible for Medicare, the Program will reduce our benefits by the amount Medicare would have paid for the services. Except as otherwise required by law, this reduction is made even if: you fail to enroll in Medicare; you do not pay the charges for Medicare; or you receive services at a Facility that cannot bill Medicare.

However, this exclusion will not apply to you if one of the following applies:

- A. **Eligibility for Medicare By Reason of Age.** You are entitled to benefits under Medicare by reason of your age, and the following conditions are met:
  - (1) The employee or member of the Group is in “current employment status” (working actively and not retired) with the Group; and
  - (2) The Group maintains or participates in an employer group health plan that is required by law to have this Program pay its benefits before Medicare.

- B. **Eligibility for Medicare By Reason of Disability Other than End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of disability (other than end-stage renal disease), and the following conditions are met:
- (1) The employee or member of the Group is in “current employment status” (working actively and not retired) with the Group; and
  - (2) The Group maintains or participates in a large group health plan, as defined by law, which is required by law to have this Program pay its benefits before Medicare pays.
- C. **Eligibility for Medicare By Reason of End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. The Program will not reduce this Program’s benefits, and the Program will provide benefits before Medicare pays, during the waiting period. The Program will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before benefits are provided under this Program.
12. **Hypnosis/Biofeedback.** The Program will not provide coverage for hypnosis or biofeedback.
13. **Military Service-Connected Conditions.** The Program will not provide coverage for any service or care related to any military service-connected disability or condition, if the Veterans Administration has the responsibility to provide the service or care.
14. **No-Fault Automobile Insurance.** The Program will not provide coverage for any service or care for which benefits are available under mandatory no-fault automobile insurance, until you have used up all of the benefits of the mandatory no-fault policy. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy. Benefits will be provided for services covered under this Program when you have exceeded the maximum benefits of the no-fault policy. Should you be denied benefits under the no-fault policy because it has a Deductible, the Program will provide coverage for the services covered under this Program, up to the amount of the Deductible. The Program will not provide benefits even if you bring a lawsuit against the person who caused your injury and even if you receive money from that lawsuit and you have repaid the medical expenses for which you received payment for under the mandatory automobile no-fault coverage.
15. **Personal Comfort Services.** The Program will not provide coverage for any service or care that is for personal comfort or for uses not primarily medical in nature, including, but not limited to: radios, telephones, televisions, air conditioners, humidifiers,

dehumidifiers, and air purifiers; beauty and barber services; commodes; and exercise equipment or orthotics used solely for sports.

16. **Private Duty Nursing Service.** The Program will not provide coverage for service or care provided by a private duty registered nurse or licensed practical nurse, even if ordered by your physician or licensed health care professional.
17. **Self-Help Diagnosis, Training And Treatment.** The Program will not provide coverage for any service or care related to self-help or self-care diagnosis, training, and treatment for recreational, educational, vocational, or employment purposes.
18. **Services Starting Before Coverage Begins.** If you are receiving care on the day your coverage under this Program begins, the Program will not provide coverage for any service or care you receive:
  - A. Prior to the first day of your coverage under this Program; or
  - B. On or after the first day of your coverage under this Program, if that service or care is covered under any other health benefits contract, program, or plan.

You must notify Excellus BlueCross BlueShield, within 48 hours after your coverage begins, that you are receiving care.

19. **Special Charges.** The Program will not provide coverage for charges billed to you for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, or completion of claims forms. This exclusion applies to any late charges or extra day charges that you incur upon discharge from a Facility, because you did not leave the Facility before the Facility's discharge time.
20. **Social Counseling And Therapy.** The Program will not provide coverage for any service or care related to family, marital, religious, sex, or other social counseling or therapy, except as otherwise explicitly provided in this Booklet.
21. **Transsexual Surgery and Related Services.** The Program will not provide coverage for any service or care related or leading up to transsexual surgery, including, but not limited to, hospitalizations; hormone therapies; procedures, treatments, or related services designed to alter the physical characteristics of your biologically determined gender to those of another gender, even if you have been diagnosed as having gender role or psychosexual orientation problems.
22. **Unlicensed Provider.** The Program will not provide coverage for any service or care that is provided or prescribed by an unlicensed provider, or that is outside the scope of licensure of the duly licensed provider rendering the service or care.

23. **Weight Loss Services.** The Program will not provide coverage for any service or care in connection with weight reduction or dietary control, including, but not limited to, gastric stapling, gastric by-pass, gastric bubble, other surgery that is determined to be medically inappropriate for treatment of obesity, or weight loss programs.
  
24. **Workers' Compensation.** The Program will not provide coverage for any service or care for which benefits are available to you under a workers' compensation or similar law. The Program will not provide coverage for the service or care even if you do not receive the benefits available, under the law because a proper or timely claim for the benefits was not submitted; or you fail to appear at a workers' compensation hearing. The Program will not provide coverage even if you bring a lawsuit against the person who caused your injury or condition and even if you receive money from that lawsuit and you have repaid the medical expenses for which you received payment under a workers' compensation law or similar legislation.

## SECTION FIFTEEN- COORDINATION OF BENEFITS

This Section applies only if you also have other group health benefits coverage with another health benefits program or plan.

1. **When You Have Other Health Benefits.** It is not unusual to find yourself covered by two health insurance contracts, plans, or policies (“plans”) providing similar benefits both issued through or to groups. When that is the case and you receive an item of service that would be covered by both plans, the Program will coordinate benefit payments with any payment made under the other plan. One plan will pay its full benefit as the primary plan. The other plan will pay secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance plan:
  - A. Any group or blanket insurance contract, plan, or policy, including HMO and other prepaid group coverage, except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan, or policy;
  - B. Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;
  - C. Any Blue Cross Blue Shield, or other service type group plan;
  - D. Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and
  - E. Medical benefits coverage in group or individual mandatory automobile "no-fault" or traditional "fault" type contracts.
2. **Medicare Eligibility Due to Age.** Members are eligible for Medicare on the first of the month of their 65th birthday. If their birthday is on the first of the month, they are eligible on the first of the previous month.
  - A. Primacy for age eligible members is determined by the subscriber’s employment status as well as the size of the group. When determining primacy for a spouse, primacy is based on the employee’s employment status, not the spouse.
  - B. Excellus is primary when the subscriber is actively working and the group employs 20 or more.



- C. Medicare is primary when the subscriber is retired, regardless of group size.
- D. Medicare is also primary when the group employs less than 20 employees, regardless of employment status.

**3. Medicare Eligibility Due to Disability.** Members may be eligible for Medicare due to a disability (not including ESRD).

- A. Omnibus Budget Reconciliation Act (OBRA) is Medicare as a Secondary Payer (MSP) for disabled under age 65 individuals that are disabled, drawing their Social Security benefits, are under age 65 and are enrolled in an Employer Group Health Plan (EGHP) that employs over 100 individuals.
- B. Primacy for disabled eligible members is determined by the subscriber's employment status as well as the size of the group. When determining primacy for a spouse, primacy is based on the employee's employment status, not the spouse.
- C. Excellus is primary when the subscriber is actively working and the group employs 100 or more employees.
- D. Medicare is primary when the subscriber is not actively working, regardless of group size.
- E. Medicare is also primary when the group employs less than 100 employees, regardless of employment status.

**4. Medicare Eligibility Due to ESRD**

- A. If a member currently has Medicare and BCBS is primary; the member receives the full 30 month coordination period.
- B. If a member currently has Medicare and Medicare is primary; Medicare remains primary.
- C. If a member is not currently enrolled in Medicare due to age or disability, they are entitled to Medicare based on the type of dialysis they receive.
- D. Facilitated dialysis – Member is entitled to Medicare on the first day of the 3rd month after month dialysis begins. This is due to Medicare having a three month waiting period for the condition.

- E. Self dialysis – Member is entitled to Medicare on the first day of the month that self dialysis begins (most common Peritoneal). The three month waiting period is waived.
- F. If a member receives a kidney transplant during the three month waiting period, the 30 month coordination period begins the first of the month that the transplant occurs.
- G. If a member receives a kidney transplant during the 30 month coordination period, the member receives the full coordination period.
- H. There is a separate 30 month coordination period each time a member enrolls in Medicare based on ESRD. When member becomes re-entitled for Medicare, the three month waiting period is waived.
- I. If a member has Medicare only due to ESRD, Medicare coverage will end:
  - a. 12 months after the month the member stops dialysis treatments, or
  - b. 36 months after the month the member had a successful kidney transplant.
  - c. In order to remove the member’s Medicare information once Medicare is terminated, documentation from Social Security showing the end date of Medicare will be required.
  - d. There is a separate 30 month coordination period each time a member enrolls in Medicare based on ESRD.

5. **Medicare Deductibles and Coinsurance.**

- A. Medicare Part A. This is hospital insurance. Covers any inpatient services rendered by a facility as long as the care is considered medically necessary and not custodial. Also considers skilled nursing facility services.
- B. Medicare Part B. This is professional services insurance. Covers non-routine services rendered in the outpatient department of a hospital, clinic or in a doctor's office.
- C. Medicare Deductible. Medicare has a deductible for both contracts it offers. Part A has an inpatient deductible equivalent to an average one-day stay in the hospital. Part B has an annual deductible. This must be met per year, per individual. When the deductible is met, Medicare will start considering claims and make reimbursement.
- D. Medicare Coinsurance. Medicare also has coinsurance for both part A and B. There is coinsurance for hospital inpatient services, outpatient hospital services and physician billed services.

E. Full Excellus BlueCross BlueShield Days. Once Medicare's basic benefits have been exhausted, Excellus BlueCross BlueShield will cover the balance of the inpatient stay up to the patient's contract liability.

2. **Rules to Determine Payment.** In order to determine which plan is primary, certain rules have been established. The first of the rules listed below which applies shall determine which plan shall be primary:

- A. If the other plan does not have a provision similar to this one, then it will be primary;
- B. If you are covered under one plan as an employee, subscriber, or member and you are only covered as a dependent under the other plan, the plan which covers you as an employee, subscriber, or member will be primary; or
- C. Subject to the provisions regarding separated or unmarried parents below, if you are covered as a child under both plans, the plan of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the plan which covered the parent longer is primary. If the other plan does not have the rule described immediately above, but instead has a rule based on gender of a parent and, as a result, the plans do not agree on which shall be primary, then the father's plan will be primary.

There are special rules for a child of separated or unmarried parents:

- (1) If the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.
- (2) If no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:
  - (a) First, the plan of the parent with custody of the child;
  - (b) Then, the plan of the spouse of the parent with custody of the child;
  - (c) Finally, the plan of the parent not having custody of the child.

- D. If you are covered under one of the plans as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, and you are covered as a laid-off or retired employee or a laid-off or retired employee's dependent under the other plan, the plan covering you as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.
- E. If none of the above rules determine which plan shall be primary, then the plan which has covered you for the longest time will be primary.

3. **Payment Of The Benefit When This Program Is Secondary.** This Program uses a Coordination of Benefits (COB) methodology. The intent of COB is to pay benefits such that the combined maximum benefits a person can receive from Medicare and this Program will not exceed the total covered allowable expenses by either contract. If you are entitled to Medicare and enrolled in this Program, Medicare will pay claims as primary and this Program will pay secondary benefits if necessary to cover all or some of your remaining expenses.

For example, when this Program is secondary, if the benefits of the primary plan are less than the normal benefits of this Program, then this Program will pay the difference between the primary plan's benefits and this Program's normal benefit.

If the benefits of the primary plan pay the same or more than the normal benefits of this Program, then this Program pays nothing.

The Program counts as actually paid by the primary plan any items of expense that would have been paid if you had made the proper and timely claim. The Program will request information from that plan so we can process your claims. If the primary plan does not respond within 30 days, it will be assumed that its benefits are the same as this Program's. If the primary plan sends the information after 30 days, payment will be adjusted, if necessary.

Although it is not a requirement of this Section, when you have coverage under more than one health plan, you can help to maximize the benefits available to you by following the rules and protocols of both the primary and secondary plans.

4. **Right to Receive And Release Necessary Information.** The Group and Excellus BlueCross BlueShield have the right to release or obtain information which they believe necessary to carry out the purpose of this Section. They need not tell you or obtain anyone's consent to do this except as required by Article 25 of the New York General Business Law. Neither the Group nor Excellus BlueCross BlueShield will be legally responsible to you or anyone else for releasing or obtaining this information. You must

furnish to us any information that is requested. If you do not furnish the information, payments may be denied.

5. **Payments To Others.** The Program may repay to any other person, insurance company, or organization the amount which it paid for your covered services and which the Program should have paid. These payments are the same as benefits paid.
  
6. **The Program's Right To Recover Overpayment.** In some cases, the Program may have made payment even though you had coverage under another plan. Under these circumstances, you must refund to the Group or the Program the amount by which the Program should have reduced its payment. The Group or the Program also have the right to recover the overpayment from the other health benefits plan if they have not already received payment from that other plan. You must sign any document which is necessary to help the Program recover any overpayment.

## SECTION SIXTEEN - TERMINATION OF YOUR COVERAGE

Described below are the reasons why your coverage under this Program may terminate.

All terminations are effective on the date specified.

1. **Termination Of The Program.** Your benefits under the Program may be terminated at any time, if the Group ends the Program.
2. **Termination Of Your Coverage Under the Program.** In the following instances, the Program will continue in force, but your coverage under the Program will be terminated:
  - A. You choose to terminate your coverage due to a qualifying event or during the annual open enrollment. You must give the Group thirty (30) days' written notice. Your coverage will terminate on the date of the qualifying event or the date your form is completed, whichever is later. Termination during the annual open enrollment will be effective at the end of the current calendar year.
  - B. You are no longer an employee or member of the Group. Your coverage will terminate on the date to which your contributions are paid if you are no longer a Member of the Group;
  - C. You committed fraud in applying for coverage or in filing a claim under this Program. Your coverage will terminate thirty (30) days from the date notice is provided to you;
  - D. Your widow/widower and unmarried surviving dependents are eligible for coverage under a University Health Care Plan if:
    - You had met the age and service requirements to retire, or
    - You were retired, or
    - You had five or more years of service but had not met the criteria to retire. (In this instance, your surviving spouse and eligible dependent children remain eligible for a period of one year following your death.)Individuals represented by collective bargaining agreements receive benefits in accordance with those agreements. Copies of those agreements are available upon request.
  - E. Termination of the retired employee or member of the Group's marriage or domestic partnership. If the retired employee or member of the Group becomes divorced or there has been a termination of the domestic partnership, or the retired employee or member of the Group's marriage is annulled, coverage of the employee's spouse or domestic partner under this Program will automatically terminate on the date of the divorce, annulment or termination of domestic partnership; or

F. Termination of coverage of a child. Coverage of an employee or member of the Group's child under this Program will automatically terminate on the date the child no longer qualifies as a dependent under Section Two of this Booklet.

3. **Temporary Continuation Of Coverage.** Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write your Group to find out if you are entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

## SECTION SEVENTEEN - RIGHT TO NEW CONTRACT AFTER TERMINATION

You have the right to convert to an insured health benefits contract issued by Excellus BlueCross BlueShield if your coverage under this Program terminates under the circumstances described below so long as you continue to live, work, or reside in Excellus BlueCross BlueShield's Service Area.

1. **Termination Of The Program.** If the Program is terminated as set forth in Section Sixteen, Paragraph 1, and the Group has not replaced the coverage for the Group with similar and continuous health care coverage, whether insured or self-insured, you are entitled to purchase an insured health benefits contract from Excellus BlueCross BlueShield as a direct payment member.
2. **If You Are No Longer Covered in the Group.** If your coverage under this Program terminates under Section Sixteen, Paragraph 2(B) because you are no longer an employee or member of the Group, you are entitled to purchase an insured health benefits contract from Excellus BlueCross BlueShield as a direct payment member.
3. **On The Death of the Employee or Member of the Group.** If your coverage under this Program terminates under Section Sixteen, Paragraph 2(D) because of the death of the employee or member of the Group, you are entitled to purchase an insured health benefits contract from Excellus BlueCross BlueShield as a direct payment member.
4. **Termination of Your Marriage or Domestic Partnership.** If your coverage under this Program terminates under Section Sixteen, Paragraph 2(E) because you become divorced from the employee or there has been a termination of your domestic partnership with the employee of the Group, or your marriage is annulled, you may be eligible to purchase an insured health benefits contract from Excellus BlueCross BlueShield as a direct payment member.
5. **Termination of Coverage of a Child.** If your coverage under this Program terminates under Section Sixteen, Paragraph 2(F) because you no longer qualify as a child, you are entitled to purchase an insured health benefits contract from Excellus BlueCross BlueShield as a direct payment member.
6. **When to Apply for the New Contract.** If you are entitled to purchase a new contract, as described above, you must apply to Excellus BlueCross BlueShield for the new contract within 45 days after termination of your coverage under this Program. You must also pay the first premium of the new contract within this same 45-day period.

However, notwithstanding the above, if Excellus BlueCross BlueShield determines, in its sole judgment, that you do not reside in New York State, you will not be entitled to purchase a new contract as a direct payment subscriber if:



- A. Excellus BlueCross BlueShield determines that similar coverage is available through the local Blue Cross and/or Blue Shield Plan operating in the area in which you have located; and
  - B. The time you were covered under this Program will count towards any applicable waiting periods under the available coverage.
7. **The New Contract.** The new contract will be Excellus BlueCross BlueShield's standard HMO contract issued upon conversion; or the new contract will be the type of coverage most commonly issued by Excellus BlueCross BlueShield to group remitting agents. The new contract may not include any coverage for: prescription drugs; any routine vision or eyewear; durable medical equipment; external prosthetic devices; orthotic devices; medical supplies; inpatient chemical dependence detoxification and rehabilitation; and mental health services.

## SECTION EIGHTEEN - GENERAL PROVISIONS

1. **No Assignment.** You cannot assign any benefits or monies due under this Program to any person, corporation, or other organization. Any assignment by you will be void. Assignment means the transfer to another person or to an organization of your right to the services provided under this Program or your right to collect money for those services.
2. **Notice.** Excellus BlueCross BlueShield will give you identification cards, booklets, riders, other necessary materials, and all notices which Excellus BlueCross BlueShield is required to give to you under this Program. If you have to give Excellus BlueCross BlueShield any notice, it should be mailed to 165 Court Street, Rochester, NY 14647.
3. **Your Medical Records.** In order for your coverage under this Program to be provided, it may be necessary for Excellus BlueCross BlueShield and/or the Group to obtain your medical records and information from Facilities or Professional Providers, Providers of Additional Health Services and pharmacy who provided services to you. Actions to provide that coverage include processing your claims, reviewing grievances or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you become covered under this Program, you automatically give Excellus BlueCross BlueShield and the Group permission to obtain and use those records for those purposes.

Excellus BlueCross BlueShield and the Group agree to maintain that information in accordance with state and federal confidentiality requirements. However, you automatically give Excellus BlueCross BlueShield permission to share that information with the New York State Department of Health, quality oversight organizations, and third parties with which Excellus BlueCross BlueShield contracts to assist it in administering this Program, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

4. **Who Receives Payment Under This Program.** Payments under this Program for service provided by an In-Network Provider will be made directly to the In-Network Provider. If you receive services from an Out-of-Network Provider, payment may be made to either you or the Out-of-Network Provider at the discretion of the Program or Excellus BlueCross BlueShield.
5. **Time To File Claims.** Claims for services under this Program must be submitted for payment within 12 months after you receive the services for which payment is being requested.
6. **Time To Sue.** No action at law or in equity may be maintained against Excellus BlueCross BlueShield or the Program to recover benefits under the Program prior to the expiration of 60 days after written submission of a claim for such benefits has been

furnished to the Program as required in this Booklet. In addition, no legal action may be commenced or maintained to recover benefits under this Program more than twenty four months after the date you received the service for which you want the Program to pay.

7. **Venue For Legal Action and Choice of Law.** If a dispute arises under this Program, it must be resolved in Federal court located in the State of New York. You agree not to start a lawsuit against the Program or Excellus BlueCross BlueShield in a court anywhere else. You also consent to these courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order you to defend any action brought against you by Excellus BlueCross BlueShield or the Program. This Program shall be governed by Federal laws and the laws of the State of New York.
8. **Recovery Of Overpayments.** On occasion a payment will be made when you are not covered, for a service which is not covered, or which is more than is proper. When this happens, the problem will be explained to you and you must return the amount of the overpayment within 60 days after receiving notification.
9. **Right To Offset.** If the Program makes a claim payment to you or on your behalf in error or you owe the Program any money, you must repay the amount you owe. If the Program owes you a payment for other claims received, any amount you owe to the Program may be subtracted from any payment the Program owes you.
10. **Continuation Of Benefit Limitations.** Some of the benefits under this Program are limited to a specific number of visits per Calendar Year, and/or subject to deductible or annual and/or lifetime maximums. You will not be entitled to any additional benefits if your participant status should change during the Calendar Year. For example, if you convert from dependent to employee or member of the Group, all benefits previously utilized during the Calendar Year will be applied toward your new participant status.
11. **Eligibility For Benefits.** A determination by Excellus BlueCross BlueShield with respect to eligibility for benefits under this Program or the construction of any of the terms of this Program which may apply in any way to any claim you might make, or any rights you might have, under this Program shall be final and binding on you so long as the determination or construction is not arbitrary or capricious.
12. **Subrogation.** If a Member becomes injured or ill because of the actions or inactions of a third party, the Program shall have the right to pursue a claim against the third party for expenses paid by the Program related to such injury or illness. If so requested by Excellus BlueCross BlueShield, the Member (or if a minor, his or her parent or legal guardian) shall:
  1. provide proof, satisfactory to Excellus BlueCross BlueShield, that no right, claim, interest or cause of action against a third party has been, or

will be, discharged or released without the written consent of Excellus BlueCross BlueShield;

2. execute a written agreement assigning to the Program all rights, claims, interests, and causes of action that the Member has against a third party in connection with the expenses paid by the Program;
3. authorize the Program, in writing, to sue, compromise or settle, in the Member's name or otherwise, all rights, claims, interests, or causes of action to the extent of benefits paid by the Program and shall do nothing to prejudice the rights given to the Program under this section; and
4. agree, in writing, to assist the Program in prosecuting any rights, interests, claims, or causes of action that have been assigned to the Program against a third party, including, if requested by Excellus BlueCross BlueShield or the Group, the institution of a formal proceeding against a third party.

**B. Program's Right of Recovery.** If a Member becomes injured or ill because of the actions or inactions of a third party, the Program shall have the right to recover related Program expenses out of any payments made by (or on behalf of) the third party (whether by lawsuit, settlement, or otherwise) to a Member (or his or her assignee). The Program's right of recovery applies to the extent the Program has paid expenses related to the injury or illness, regardless of whether any related settlement or other third-party payment states that the payment (all or part of it) is for health care expenses. By accepting benefits under the Program to pay for treatments, devices or other products or services related to such injury or illness, Member agrees to place such third-party payments in Member's separate identifiable account (in an amount equal to related expenses paid by the Program or, if less, the full third-party payment amount) and that the Program has an equitable lien on such funds, without regard to whether the Member has been made whole or fully compensated for the injury or illness. Member also agrees to serve as a constructive trustee over the funds until the time they are paid to the Program. Member further agrees to cooperate with the Program's recovery efforts and do nothing to prejudice the Program's recovery rights. The Program is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) incurred in obtaining the funds.

**C. Enforcement of Program's Subrogation and Recovery Rights.** Should it be necessary for the Program to institute proceedings against the Member for failure to reimburse the Program or to otherwise honor the Program's equitable interest in obtaining amounts described in this section 17.12, the Member shall be liable for the costs of collection relating to such failure, including reasonable attorney's fees.

The Program shall have the right to offset future benefits to which a Member may be entitled, until the amount otherwise due the Program under this section 17.12, plus interest, has been received by the Program.

The Program's rights under this section 17.12 shall be enforceable regardless of whether the third party admits liability for the injury or illness to a Member, and shall remain enforceable against the heirs and estate of any Member.

13. **Who May Change This Program.** The Program may not be modified, amended, or changed, except in writing, and signed by an authorized representative of the Group. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the Program in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by an authorized representative of the Group.
14. **Changes In This Program.** The Group may unilaterally change this Program at any time.
15. **Agreements Between Excellus BlueCross BlueShield and In-Network Providers.** Any agreement between Excellus BlueCross BlueShield and In-Network Providers may be terminated by Excellus BlueCross BlueShield or the providers. This Program does not require any provider to accept you as a patient. Neither Excellus BlueCross BlueShield nor the Group guarantees your admission to any In-Network Provider or any health benefits program.
16. **Notice of Claim.** Claims for services under this Program must include all information designated by Excellus BlueCross BlueShield, the Group, and/or the Program as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, social security number, and supporting medical records, when necessary. A claim that fails to contain all necessary information may be denied.
17. **Notice of Claim Determination.** You will be provided an explanation of benefits when a claim is denied in whole or in part and, as a result, you incur out of pocket expenses other than any applicable Deductibles, Coinsurance, or Copayments.
18. **Identification Cards.** Identification cards are issued for identification only. Possession of any identification card confers no right to services or benefits under this Program. To be entitled to such services or benefits your contributions must be paid in full at the time that the services are sought to be received. Coverage under this Program may be terminated if you allow another person to wrongfully use the identification cards.
19. **Right to Develop Guidelines and Administrative Rules.** Excellus BlueCross Blue Shield and/or the Group may develop or adopt standards which describe in more detail when payments will or will not be made under this Program. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether emergency care in the outpatient department of a Facility was necessary; or whether certain services are Skilled Care. Those standards will not be contrary to the

descriptions in this Booklet. If you have a question about the standards which apply to a particular benefit, you may contact Excellus BlueCross BlueShield or the Group and the standards will be explained or sent to you. Excellus BlueCross BlueShield and/or the Group may also develop administrative rules pertaining to enrollment and other administrative matters. Excellus BlueCross BlueShield and the Group shall have all the powers necessary or appropriate to carry out their respective duties in connection with the administration of this Program.

20. **Enrollment; ERISA.** The Group will develop and maintain complete and accurate payroll records, as well as records of the names, addresses, ages, and social security numbers of all persons covered under this Program, and any other information required to confirm their eligibility for coverage. The Group will provide Excellus BlueCross BlueShield with the enrollment form including your name, address, age, and social security number and advise Excellus BlueCross BlueShield in writing when you are to be added to or subtracted from the list of Members, on a monthly basis. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 60 days.

The Group may also have additional responsibilities as the “plan administrator”, as defined in the Employee Retirement Security Act of 1974, as amended (“ERISA”). The “plan administrator” is the Group, or a third-party appointed by the Group. Excellus Health Plan, Inc. is not the ERISA plan administrator.

21. **Reports and Records.** Excellus BlueCross BlueShield and the Group are entitled to receive, from any provider of services to you, information reasonably necessary to administer this Program subject to all applicable confidentiality requirements as defined in the General Provisions Section of this Booklet. By accepting coverage under this Program, the employee or member of the Group, for himself or herself, and for all dependents covered hereunder, authorizes each and every provider who renders services to any of the foregoing to:
- A. Disclose all facts pertaining to the care, treatment, and physical condition of the patient to Excellus BlueCross BlueShield, the Group, or a medical, dental, or mental health professional that either of them may engage to assist in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
  - B. Render reports pertaining to the care, treatment, and physical condition of the patient to Excellus BlueCross BlueShield and/or the Group, or a medical, dental, or mental health professional that either of them may engage to assist in reviewing a treatment or claim; and
  - C. Permit copying of the Member’s records by Excellus BlueCross BlueShield and/or the Group.

22. **Inability to Provide Service.** In the event that due to circumstances not within the reasonable control of Excellus BlueCross BlueShield or the Group, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the network, the rendition of medical or Facility benefits or other services provided under this Program is delayed or rendered impractical, Excellus BlueCross BlueShield and the Group shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid contributions held by the Group or the Program on the date such event occurs. Excellus BlueCross BlueShield and the Group are required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.
23. **Service Marks.** Excellus Health Plan, Inc., d/b/a Excellus BlueCross BlueShield, Rochester Region, is an independent corporation organized under the Insurance Law of New York State. Excellus BlueCross BlueShield also operates under licenses with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, which licenses it to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus BlueCross BlueShield does not act as an agent of the Blue Cross and Blue Shield Association, and is solely responsible for honoring its obligations created under the Administrative Services Contract between the Group and Excellus BlueCross BlueShield.
24. **Inter-Plan Arrangements Disclosure - Out-of-Area Services.** Excellus BlueCross BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain health care services outside of the Excellus BlueCross BlueShield Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program.

Typically, when accessing care outside the Service Area, you will obtain care from health care providers that have a contractual agreement (i.e., are “In-Network Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from Out-of-Network Providers. Excellus BlueCross BlueShield’s payment practices in both instances are described below.

- A. **BlueCard® Program.** Under the BlueCard® Program, when you access covered health care services within the geographic area served by a Host Blue, Excellus BlueCross BlueShield will remain responsible to Group for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its In-Network Providers.

Whenever you access covered health care services outside the Excellus BlueCross BlueShield Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is

calculated based on the lower of:

- (1) The provider's billed covered charges for your covered services; or
- (2) The negotiated price that the Host Blue makes available to Excellus BlueCross BlueShield. This negotiated price will be one of the following:
  - (a) Often, a simple discount that reflects an actual price that the Host Blue pays to your provider;
  - (b) Sometimes, an estimated price that takes into account special arrangements with your provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges; or
  - (c) Occasionally, an average price, based on a discount that results in expected average savings for similar types of providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Excellus BlueCross BlueShield uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, Excellus BlueCross BlueShield would then calculate your liability for any covered health care services according to applicable law.

- B. Calculation of Member Liability for Services of Out-of-Network Providers outside Excellus BlueCross BlueShield Service Area.** The Allowable Expense definition in this booklet, as amended from time-to-time, describes how Excellus BlueCross BlueShield's payment (the "Allowable Expense") for covered services of Out-of-Network Providers outside its Service Area is calculated. The Allowable Expense may be based upon the amount provided to Excellus BlueCross BlueShield by the Host Blue or the payment it would make to Out-of-Network Providers inside its Service Area. Regardless of how the Allowable Expense is calculated, you will be liable for the amount, if any, by which the provider's actual charge exceeds the Allowable Expense, which amount is in addition to any other cost-sharing (Deductible, Copayment or Coinsurance) required by this Program.

25. **Grievance Procedures.** Procedures have been established to resolve your grievances.



These procedures make sure that questions, concerns, and complaints are resolved in a timely, fair manner.

- A. **Filing a Grievance.** The Grievance Procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination. To initiate a grievance, just contact Excellus BlueCross BlueShield. All requests and discussions are confidential and no discriminatory action will be taken because you filed a grievance. There is a process for both standard and expedited grievances, depending on the nature of your inquiry. A file is maintained on each grievance.

You can either contact Excellus BlueCross BlueShield's Customer Service Department by phone, in person or in writing to file a grievance. You or your designee has up to 180 calendar days to file the grievance from when you received the decision you are asking be reviewed.

When Excellus BlueCross BlueShield receives your grievance, it will mail an acknowledgement letter within 15 business days. This acknowledgment letter will include the name, address and telephone number of the person handling your grievance, and indicate what additional information, if any, must be provided.

Excellus BlueCross BlueShield will decide your grievance and notify you of its determination in writing within 30 calendar days of receipt of your grievance request.

If your grievance relates to an urgent matter, Excellus BlueCross BlueShield will decide the grievance and notify you of its determination by phone within 48 hours of receipt of your grievance request. Written notice will follow within 24 hours of the determination.

Qualified personnel will review your grievance, or if it is a clinical matter, a licensed, certified, or registered health care professional will look into it.

- B. **Notice of Determination.** The notice of determination of your grievance will include detailed reasons and if a clinical matter is involved, the clinical rationale, and further appeal rights, if any. Excellus BlueCross and BlueShield will send notices to you or your representative and to your health care provider.
26. **Utilization Review.** Excellus BlueCross BlueShield reviews proposed and rendered health services to determine whether the services are or were Medically Necessary or experimental or investigational (for purposes of this Paragraph only, these will be collectively referred to as "Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being rendered ("prospective"); when the service is being rendered (concurrent); or after the service is rendered (retrospective).

Excellus BlueCross BlueShield has developed Utilization Review policies to assist it in administering the Utilization Review program. These policies describe the process and procedures of Utilization Review activities. Reviews are conducted by registered nurses and Excellus BlueCross BlueShield's Medical Directors. All determinations that services are not Medically Necessary will be made by licensed physicians. Excellus BlueCross BlueShield does not compensate or provide financial incentives to its employees or reviewers for determining that services are not or were not Medically Necessary. Excellus BlueCross BlueShield has developed guidelines and protocols to assist it in this process. Specific guidelines and protocols are available for your review. For more information, you can contact Excellus BlueCross BlueShield.

- A. **Prospective Reviews.** All requests for prior authorization of care are reviewed for Medical Necessity (including the appropriateness of the proposed level of care and/or provider). The initial review is performed by a nurse. If the nurse determines that the proposed care is Medically Necessary, the nurse will authorize the care. If the nurse determines that the proposed care is not Medically Necessary or that further evaluation is needed, the nurse will refer the case to a licensed physician.

If Excellus BlueCross BlueShield has all the information necessary to make a determination regarding a prospective review, it will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing within three business days of receipt of the request. If Excellus BlueCross BlueShield needs additional information, it will request it within three business days. You or your provider will then have 45 calendar days to submit the information. Excellus BlueCross BlueShield will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of the earlier of its receipt of the information or the end of the 45-day time period.

With respect to urgent prospective claims, if Excellus BlueCross BlueShield has all information necessary to make a determination, it will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing within 72 hours of receipt of the request. If Excellus BlueCross BlueShield needs additional information, it will request it within 24 hours. You or your provider will then have 48 hours to submit the information. Excellus BlueCross BlueShield will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

- B. **Concurrent Reviews.** When you are receiving services that are subject to concurrent review, a nurse will periodically assess the Medical Necessity and appropriateness of care you receive throughout the course of treatment. Once a case is assigned for concurrent review, a nurse will determine whether the services are Medically Necessary. If so, the nurse will authorize the care. If the nurse determines that Medical Necessity is lacking or that further evaluation is

needed, the nurse will refer the case to a licensed physician.

Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to your provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision, but no later than 15 calendar days of receipt of the request.

For concurrent reviews that involve urgent matters, Excellus BlueCross BlueShield will make a determination and provide notice to you and your provider within 24 hours of receipt of the request.

If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.

- C. **Retrospective Reviews.** At Excellus BlueCross BlueShield's option, a nurse will review retrospectively the Medical Necessity of claims that are subject to Utilization Review. If the nurse determines that care you received was Medically Necessary, the nurse will authorize the benefits. If the nurse determines that Medical Necessity was lacking or that further evaluation is needed, the nurse will refer the case to a licensed physician.

If Excellus BlueCross BlueShield has all information necessary to make a determination regarding a retrospective claim, it will make a determination and provide notice to you and your provider within 30 calendar days of receipt of the claim. If Excellus BlueCross BlueShield needs additional information, it will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. Excellus BlueCross BlueShield will make a determination and provide notice to you and your provider within 15 calendar days of the earlier of its receipt of the information or the end of the 45-day time period.

- D. **Notice of Adverse Determination.** A notice of adverse determination (notice that a service is not Medically Necessary) will include the reasons, including clinical rationale, for Excellus BlueCross BlueShield's determination. The notice will also advise you of your right to an internal appeal of the determination and specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for Excellus BlueCross BlueShield to review an appeal. Excellus BlueCross BlueShield will send notices of determination to you or your designee and to your health care provider.

If, prior to making an adverse determination, no attempt was made to consult with the provider who recommended the service at issue, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For prospective and concurrent reviews, the reconsideration will

take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to the provider, by telephone and in writing.

- E. **Internal Appeals of Adverse Determinations.** You, your designee and, in retrospective review cases, your health care provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing.

You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. Excellus BlueCross BlueShield will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address and phone number of the person handling your appeal, and if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

Excellus BlueCross BlueShield will decide internal appeals related to prospective reviews within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and your health care provider if he or she requested the review) within two business days after the determination is made but no later than 30 calendar days after receipt of the appeal request.

Excellus BlueCross BlueShield will decide internal appeals related to retrospective reviews within 60 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and your health care provider if he or she requested the review) within two business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review, or any other urgent matter, will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

For expedited appeals, you provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request.

If you are not satisfied with the resolution of your expedited appeal, you may file

a standard internal appeal.

- F. **Notice of Determination of Internal Appeal.** The notice of determination of your internal appeal will indicate that it is a “final adverse determination” and will include the clinical rationale for our decision. Excellus BlueCross BlueShield will send notices of determination to you or your designee and to your health care provider.