

These are your

University of Rochester

PREFERRED PROVIDER ORGANIZATION BENEFITS

University PPO Plan

2015 Plan Year

This Booklet explains your University of Rochester Preferred Provider Organization PPO Plan 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.

This Program offers you the option to receive covered services on three benefit levels:

Domestic Benefits. Domestic Network Benefits are the highest level of coverage available. Domestic Network Benefits apply when your care is provided by providers in the Accountable Health Partners domestic network ("Domestic Network Providers"). You should always consider receiving health services first through the Domestic Network.

In-Network Benefits. In-Network Benefits typically are the intermediate level of coverage available. In-Network Benefits apply when your care is provided by In-Network Providers, other than Domestic Network Providers.

Out-of-Network Benefits. The Out-of-Network Benefits portion of this Program covers health care services described in this Booklet when you choose to receive the covered services from Out-of-Network Providers. When you receive Out-of-Network Benefits, you usually will incur higher out-of-pocket expenses. You will be responsible for meeting an annual Deductible and paying a Copayment or Coinsurance amount on most covered services, as well as for paying any difference between the Allowable Expense and the provider's charge.

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. **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.
- D. **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.
- E. **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.
- F. **Deductible.** A charge, expressed as a fixed dollar amount, which you must pay once each Calendar Year before the Program will pay anything for In-Network and Out-of-Network Benefits covered under this Program during that Calendar Year. (There are special Deductible rules when you have other than individual coverage. See Section Four.)
- G. **Domestic Network Benefits.** Domestic Network Benefits are the highest level of coverage available. Domestic Network Benefits apply when your care is provided by Domestic Network Providers.
- H. **Domestic Network Provider.** Accountable Health Partners, its physician practices, and other affiliated providers of Accountable Health Partners. The Group will provide you with a list of Domestic Network Providers.
- I. **Effective Date.** The date your coverage under this Program begins. Coverage begins 12:01 a.m. on the Effective Date.
- J. **Emergency Condition.** A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - (1) Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn

child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

- (2) Serious impairment to such person's bodily functions;
- (3) Serious dysfunction of any bodily organ or part of such person; or
- (4) Serious disfigurement of such person.

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

- K. **Emergency Services.** A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required "to stabilize" the patient.
- L. **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.
- M. **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) Places primarily for nursing care;
- (2) Skilled Nursing Facilities;
- (3) Convalescent homes or similar institutions;
- (4) Institutions primarily for custodial care, rest, or as domiciles;
- (5) Health resorts, spas, or sanitariums;
- (6) Infirmaries at schools, colleges, or camps;
- (7) Places primarily for the treatment of chemical dependency and abuse, hospice care, or rehabilitation; or
- (8) Free standing ambulatory surgical centers.

- N. **In-Network Benefits.** In-Network Benefits typically are the highest level of coverage available. In-Network Benefits apply when your care is provided by In-Network Providers. You will be responsible for paying an annual Deductible as well as a Copayment or a Coinsurance amount on many covered services.
- O. **In-Network Provider.** A Facility, Professional Provider, or Provider of Additional Health Services that has a PPO 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.
- P. **Life-Threatening Condition.** Any disease or condition from which the likelihood of death is probable unless the course of the disease or the condition is interrupted.
- Q. **Medical Director.** The person designated by Excellus BlueCross BlueShield to monitor quality of care and appropriate utilization of health services.
- R. **Medical Necessity.** See Section Three of this Booklet.
- S. **Member.** Any employee or member of the Group, or an eligible dependent of an employee or member 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.

- T. **Mental Health Disorder.** 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.
- U. **Out-of-Network Benefits.** The Out-of-Network Benefits portion of this Program covers health care services described in this Program when you choose to receive the covered services from Out-of-Network Providers. When you receive Out-of-Network Benefits, you usually will incur higher out-of-pocket expenses. You will be responsible for meeting an annual Deductible and for paying a Coinsurance or Copayment amount, on most covered services, as well as paying any difference between the Allowable Expense and the provider's charge.
- V. **Out-of-Network Provider.** A Facility, Professional Provider, or Provider of Additional Health Services that does not have a PPO 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.
- W. **Preferred Provider Organization (PPO).** A network of Facilities, Professional Providers, and Providers of Additional Health Services that have PPO provider agreements with Excellus BlueCross BlueShield or another Blue Cross and/or Blue Shield Plan to provide health services to persons covered under this Program.
- X. **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.
- Y. **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.

- Z. **Qualified Clinical Trial.** A phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition and is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
- (1) The National Institutes of Health;
 - (2) The Centers for Disease Control and Prevention;
 - (3) The Agency for Health Research and Quality;
 - (4) The Centers for Medicare & Medicaid Services;
 - (5) A cooperative group or center of any of the entities described in (1) through (4) above or the Department of Defense or the Department of Veterans Affairs;
 - (6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
 - (7) The Department of Veterans Affairs, Department of Defense, or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review that Health and Human Services determines (i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- AA. **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.
- BB. **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.

- CC. **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.
- DD. **“You”, “Your”, and “Yours”.** Throughout this Booklet, the words “you”, “your” and “yours” refers to you, the 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 regular full-time or part-time faculty or staff member. Full-time is defined as for hourly staff: a regular weekly work schedule of at least 35 hours; for professional, administrative, and supervisory staff: a weekly work schedule of 40 hours or more; for faculty: a normal full teaching and research load as defined for the faculty by the college or school concerned. Part-time is defined as a regular weekly or monthly schedule which is less than that required for full-time status but generally not less than 17.5 hours per week in the case of hourly and professional, administrative, and supervisory staff. For faculty it indicates that the individual carries at least half the normal (full) teaching and research load as defined for faculty by the college or school concerned.

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

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.
- 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 an employee’s domestic partner is treated as taxable income to the 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.
- 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. (See Section Sixteen of this Booklet for when coverage terminates.)

- 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. ty

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 employee or member of the Group, your spouse or eligible domestic partner, and your children, as described above, are covered;
 - B. Spousal Coverage - If spousal coverage applies, then only the employee or member of the Group, and your spouse or eligible domestic partner, as described above, are covered. You may only select spousal coverage if your family unit consists of you and your spouse or eligible domestic partner;
 - C. Child Coverage - If child coverage applies, then you, the employee or member of the Group, and your child or children, as described above, are covered; you may only select child coverage if your family unit consists of you and your eligible child(ren).

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 7 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 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 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 employee or member of the Group, 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 employee or member of the Group, 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;
 - (7) The coverage was under an HMO, and you no longer live, work or reside in the HMO service area;
 - (8) Cessation of eligible child status;
 - (9) Benefits are no longer offered to similarly situated individuals (e.g. part-time employees); or
- C. You acquire a family member due to birth, guardianship, adoption, placement for adoption, marriage, or commencement of a domestic partnership, in which case, you, the employee or member of the Group, may enroll for individual coverage or

for a type of coverage available to your Group that will cover you and your eligible family members; or

- D. You or a family member lose eligibility for coverage under Medicaid, Family Health Plus, or Child Health Plus, or you become eligible for state premium assistance under Medicaid, Family Health Plus, or Child Health Plus; and
- E. You apply for coverage under this Program within 30 days after termination for one of the reasons set forth in Subparagraph B above, or acquisition of a family member as set forth in Subparagraph C above; or you apply for coverage under this Program within 60 days after the occurrence of an event set forth in Subparagraph D above.

If you enroll for coverage pursuant to Subparagraphs A and B, or Subparagraph D, your coverage will begin at 12:01 a.m. on the date of the loss of coverage or eligibility for state premium assistance. If you enroll for coverage pursuant to Subparagraph C above, your coverage will begin at 12:01 a.m. on: the date of the birth, adoption, guardianship or placement for adoption; or, if you are entitled to special enrollment based on marriage or commencement of a domestic partnership, on the later of (i) the date of marriage or commencement of a domestic partnership, or (ii) the date the election form is completed.

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 termination of a domestic partnership; the death of your spouse or domestic partner; a Member becoming Medicare eligible, or a child reaching the age at which coverage terminates or

otherwise experiencing an event which would normally result in termination of the child's 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; radiology services, MRA, MRI, PET, and/or CT/CAT scans; all inpatient admissions (excluding maternity and routine nursery), skilled nursing facility services, home health visits; infusion therapy, hospice care, and durable medical equipment that costs more than \$200.
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. **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 Domestic Network, In-Network and Out-of-Network 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.
2. **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.
3. **Deductibles.** Except where stated otherwise, you must pay the first \$400 (Domestic Network Providers); \$800 (In-Network Providers); and \$1,600 (Out-of-Network Providers) of Allowable Expenses incurred for services covered under this Program to which the Deductible applies (as is stated in the Section of this Booklet where the particular service is described) during each Calendar Year. If you have other than individual coverage, after Deductible payments for services for any and all persons covered under the Program total \$1,000 (Domestic Network Providers); \$2,000 (In-Network Providers); or \$4,800 (Out-of-Network Providers) of Allowable Expenses in a Calendar Year, no further Deductible will be required for services for any person covered under the Program for that Calendar Year.

If you use a combination of Domestic Network, In-Network and Out-of-Network Providers, the amount you pay for the Deductible for Domestic Network, In-Network and Out-of-Network Providers is combined and the total amount you are required to pay will not exceed the Deductible amount, shown above, for Out-of-Network Providers in a Calendar Year.

4. **Additional Payments For Out-of-Network Benefits.** When you receive covered services from an Out-of-Network Provider, in addition to the Coinsurance, Copayments, and the annual Deductibles described above, you must also pay the amount, if any, by which the Out-of-Network Provider's actual charge exceeds the Allowable Expense. This means that the total of the Program's coverage and your Deductibles, Coinsurance, and/or Copayments may be less than the provider's actual charge.
5. **Maximum Annual Deductible, Copayment and Coinsurance Amounts (the "Out-of-Pocket Maximum").**
 - A. *For full-time employees that earn less than \$46,300 per year, your Out-of-Pocket Maximum is as follows:* When you have paid \$2,000 (Domestic Network Providers); \$2,500 (In-Network Providers); or \$4,000 (Out-of-Network Providers) for services covered under this Program for Deductibles, Coinsurance and Copayments (including Prescription Drug Copayments) in a Calendar Year, the Program will provide coverage for 100% of the Allowable Expense for covered services under the Program

- for the remainder of the Calendar Year. If other than individual coverage applies, when members of the same family covered under the Program have paid an aggregate of \$4,000 (Domestic Network Providers); \$5,000 (In-Network Providers); or \$8,000 (Out-of-Network Providers) for Deductibles, Coinsurance and Copayments (including Prescription Drug Copayments) in a Calendar Year, the Program will provide coverage for 100% of the Allowable Expense for covered services for the remainder of the Calendar Year. You will remain responsible for any charges of an Out-of-Network Provider that are in excess of the Allowable Expense.
- B. *For full-time employees that earn more than \$46,300 per year, your Out-of-Pocket Maximum is as follows:* When you have paid \$2,500 (Domestic Network Providers); \$3,000 (In-Network Providers); or \$4,000 (Out-of-Network Providers) for services covered under this Program for Deductibles, Coinsurance and Copayments (including Prescription Drug Copayments) in a Calendar Year, the Program will provide coverage for 100% of the Allowable Expense for covered services under the Program for the remainder of the Calendar Year. If other than individual coverage applies, when members of the same family covered under the Program have paid an aggregate of \$5,000 (Domestic Network Providers); \$6,000 (In-Network Providers); or \$8,000 (Out-of-Network Providers) for Deductibles, Coinsurance and Copayments (including Prescription Drug Copayments) in a Calendar Year, the Program will provide coverage for 100% of the Allowable Expense for covered services for the remainder of the Calendar Year. You will remain responsible for any charges of an Out-of-Network Provider that are in excess of the Allowable Expense.
- C. If you use a combination of Domestic Network, In-Network and Out-of-Network Providers, the Out-of-Pocket Maximum amount you pay for Domestic Network, In-Network and Out-of-Network Providers is combined and the total amount you are required to pay will not exceed the Out-of-Pocket Maximum, shown above, for Out-of-Network Providers in a Calendar Year.
6. **Carryover of Cost Sharing Expenses from another Group Plan within a Calendar Year.** When you switch plans within a Calendar Year from another University of Rochester plan to this Program, all cost sharing expenses that you paid under the other plan during the Calendar Year of the change will carryover to the limits applicable to this Program. Thus, if you had individual coverage under another University of Rochester plan and paid \$250 toward your Out-of-Network Deductible under that plan before switching to this Program, the \$250 would apply toward the \$1,600 Out-of-Network Deductible under Paragraph 3 of this Section. Likewise, if you incurred a total of \$850 in Coinsurance for services rendered from an Out-of-Network Provider under another University of Rochester plan, that \$850 would apply toward the \$4,000 Out-of-Pocket Maximum under Paragraph 5 of this Section. In no event shall there be any carryover of cost sharing expenses from one Calendar Year to the next.

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.** 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, surgical and mental health care and substance abuse disorder.

B. **Mental Health Inpatient Services.** The Benefit Plan provides coverage for inpatient mental health care services relating to the diagnosis and treatment of Mental Health Disorders comparable to other similar Hospital, medical and surgical coverage provided under this Benefit Plan. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- (1) A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- (2) A state or local government run psychiatric inpatient Facility;
- (3) A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- (4) A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

and, in other states, to similarly licensed or certified Facilities.

The Benefit Plan also covers inpatient mental health care services relating to the diagnosis and treatment of Mental Health Disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

C. **Substance Use Inpatient Services.** The Benefit Plan covers inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency. This includes coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services (“OASAS”); and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

The Benefit Plan also covers inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities defined in 14 NYCRR 819.2(a)(1) and to services provided in such Facilities in accordance with 14 NYCRR Parts 817 and 819; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which

are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

- D. **Skilled Nursing Facility.** The Program will provide coverage for In-Network 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 120 days in a Calendar Year.

In-Network Benefits and Out-of-Network Benefits will both be counted toward the 120-day limited described above.

- E. **Physical Medicine and Rehabilitation.** The Program will provide coverage for comprehensive physical medicine and rehabilitation (chemical dependence and abuse programs are excluded) for up to 120 days per Calendar Year for a condition that in the judgment of your In-Network Provider and the Medical Director can reasonably be expected to result in significant improvement within a relatively short period of time.

In-Network Benefits and Out-of-Network Benefits will both be counted toward the 120-day limited described above.

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.
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.
8. **Payments for Inpatient Care.**

Domestic Network Benefits. Domestic Network Benefits for inpatient care subject to this Section are covered at 90% of the Allowable Expense, after Deductible for each single confinement.

In-Network Benefits. In-Network Benefits for inpatient care subject to this Section are covered at 80% of the Allowable Expense, after Deductible for each single confinement.

Out-of-Network Benefits. Out-of-Network Benefits for inpatient care subject to this Section are covered at 60% of the Allowable Expense, after Deductible for each single confinement.

For purposes of this Section, a single confinement means one or more inpatient admissions to a Facility for the same condition if the inpatient admissions are within 90 days of a prior inpatient admission for that condition. When you are admitted to a Facility after at least 90 days during which you have not been confined for the same condition to any Facility, you will begin a new single confinement and it will be covered at 90% of the Allowable Expense, after Deductible (Domestic Network); 80% of the Allowable Expense, after Deductible (In-Network); or 60% of the Allowable Expense, after Deductible (Out-of-Network). Inpatient admissions that are for different conditions constitute separate confinements and are covered at at 90% of the Allowable Expense, after Deductible (Domestic Network); 80% of the Allowable Expense, after Deductible (In-Network); or 60% of the Allowable Expense, after Deductible (Out-of-Network).

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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

3. **Imaging.** The Program will provide coverage for diagnostic imaging procedures, including x-rays, ultrasound, computerized axial tomography (“CAT”) and positron emission tomography (“PET”) scans, and magnetic resonance imaging.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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.

Domestic Network Benefits. Domestic Network Benefits for routine mammography screenings are covered at 100% of the Allowable Expense. Domestic Network Benefits for diagnostic mammography screenings are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits for routine mammography screenings are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic mammography screenings are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of Network Benefits for routine mammography screenings are not covered. Out-of-Network Benefits for diagnostic mammography screenings are covered at 60% of the Allowable Expense, after Deductible.

- 7. **Cervical Cytology Screenings (Pap Smears).** The Program will provide coverage, subject to the limitations described below, 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 for routine cervical cytology screenings under this Section and Section Nine, Paragraph 13 is limited to two screenings per Calendar Year. 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.

Domestic Network Benefits. Domestic Network Benefits for routine cervical cytology screenings are covered at 100% of the Allowable Expense. Domestic Network Benefits for diagnostic cervical cytology screenings are covered at 90% of the Allowable Expense, after Deductible.

In-Network. In-Network Benefits for routine cervical cytology screenings are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic cervical cytology screenings are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network. Out-of-Network routine cervical cytology screenings are not covered. Out-of-Network Benefits for diagnostic cervical cytology screenings are covered at 60% of the Allowable Expense, after Deductible.

8. **Mental Health Disorder Outpatient Services.** The Benefit Plan covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of Mental Health Disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; or a professional corporation or a university faculty practice corporation thereof.

The Benefit Plan does not cover:

- A. Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- B. Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by a governmental agency; or
- C. Services solely because they are ordered by a court.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$15 Copayment.

In-Network Benefits. In-Network Benefits are subject to a \$15 Copayment.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

9. **Substance Use Outpatient Services.** The Benefit Plan covers outpatient substance use services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of alcoholism, substance use and dependency, including methadone treatment. Such coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance

abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation.

The Benefit Plan also covers outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from alcoholism, substance use and dependency; and 2) and the person receiving, or in need of, treatment for alcoholism, substance use and dependency are both covered under this Benefit Plan. The payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$15 Copayment.

In-Network Benefits. In-Network Benefits are subject to a \$15 Copayment.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

10. **Covered Therapies.** The Program will provide coverage for related rehabilitative physical therapy and physical, occupational, respiratory, 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. The coverage for related rehabilitative physical therapy and physical, occupational, and speech therapy shall be subject to an aggregate of 45 visits per Member per Calendar Year. There shall be no visit limit for respiratory therapy.

In-Network Benefits and Out-of-Network Benefits will both be counted toward this 45-visit maximum.

Services provided in a Professional Provider's office pursuant to Section Nine, Paragraph 2 and in the outpatient department of a Facility pursuant to this Section are subject to the 45-visit limit for therapies other than respiratory therapy.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$30 Copayment.

In-Network Benefits. In-Network Benefits are subject to a \$60 Copayment.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% 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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

12. **Pulmonary Rehabilitation.** The Program will provide coverage for Medically Necessary patient assessment and formal training and education phases of pulmonary rehabilitation programs. Services must be rendered by an approved pulmonary rehabilitation program provider and recommended by the Member's cardiologist or Professional Provider.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

13. **Internal Prosthetic Devices.** The Program provides coverage for outpatient care in connection with internal prostheses that were 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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

14. **Infertility Treatment Services.** The Program will provide coverage for Medically Necessary outpatient Facility care in connection with infertility treatment services provided by a Professional Provider pursuant to Section Nine, Paragraph 19.

You are responsible for any applicable Deductible or Coinsurance provisions under this Section for similar services. For example, any Deductible or Coinsurance that applies to Care in Connection with Surgery under Paragraph 1 will also apply to surgical services covered under this Paragraph, and any Deductible or Coinsurance for imaging covered under Paragraph 3 will also apply to imaging covered under this Paragraph.

15. **Qualified Clinical Trial Expenses.** The Program will provide coverage for all health care items and services for a Member for the treatment of cancer or any other Life-Threatening Condition that is consistent with the standard of care for an individual with the Member's diagnosis; provided, such health care items and services would have been covered under the Program if the Member did not participate in the Qualified Clinical Trial. To be eligible for coverage, the Member must meet the requirements of a qualifying individual, as defined below.

For purposes of this section a "qualifying individual" means a Member who is eligible to participate in a Qualified Clinical Trial according to the trial protocol with respect to the treatment of cancer or other Life-Threatening Condition; and either: (A) the referring health care professional has concluded that the Member's participation in such trial would be appropriate based upon his or her diagnosis; or (B) the Member provides scientific information establishing that the Member's participation in such trial would be appropriate based upon his or her diagnosis.

Notwithstanding the above, Qualified Clinical Trial expenses do not include the following:

- A. the experimental or investigational item, device or service, itself;
- B. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- C. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The benefits of this paragraph are subject to any applicable Deductible or Coinsurance provisions for similar services. For example, any Deductible or Coinsurance for imaging covered under Paragraph 3 will also apply to imaging covered under this Paragraph.

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 unlimited home care visits in a Calendar Year.
6. **Payments For Home Care.**

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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 also provide coverage for up to five visits for bereavement counseling services to your family, either before or after your death.

- 5. **Payments for Hospice Care.**

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

- 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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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

Domestic Network Benefits. Domestic Network Benefits are subject to a \$15 Copayment if services are rendered by a primary care physician or \$30 Copayment if services are rendered by a specialist.

In-Network Benefits. In-Network Benefits are subject to a \$30 Copayment if services are rendered by a primary care physician or \$60 Copayment if services are rendered by a specialist.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

2. **Covered Therapies.** The Program will provide coverage for related rehabilitative physical therapy and physical, occupational, respiratory, and speech therapy when services are rendered by a licensed physical therapist, occupational therapist, or speech language pathologist or audiologist and when it is determined that your condition is subject to significant clinical improvement through relatively short-term therapy. The coverage for related physical therapy and physical, occupational, and speech therapy shall be subject up to an aggregate of 45 visits per Member per Calendar Year. There shall be no visit limit for respiratory therapy.

In-Network Benefits and Out-of-Network Benefits will both be counted toward the 45-visit maximum.

Services provided in the outpatient department of a Facility pursuant to Section Six, Paragraph 10 and in a Professional Provider's office pursuant to this Section are subject to the 45-visit limit, for therapies other than respiratory therapy.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$30 Copayment.

In-Network Benefits. In-Network Benefits are subject to a \$60 Copayment.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after 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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$15 Copayment if services are rendered by a primary care physician or \$30 Copayment if services are rendered by a specialist.

In-Network Benefits. In-Network Benefits are subject to a \$30 Copayment if services are rendered by a primary care physician or \$60 Copayment if services are rendered by a specialist..

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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. You will be entitled to In-Network Benefits when your Professional Provider provides a written referral to an Out-of-Network Professional Provider.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$15 Copayment if services are rendered by a primary care physician or \$30 Copayment if services are rendered by a specialist.

In-Network Benefits. In-Network Benefits are subject to a \$30 Copayment if services are rendered by a primary care physician or \$60 Copayment if services are rendered by a specialist.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% 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).

Domestic Network Benefits. Domestic Network Benefits for prenatal and postnatal care are covered at 100% of the Allowable Expense. Domestic Network Benefits for hospital care of the mother are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits for prenatal and postnatal care are covered at 100% of the Allowable Expense. In-Network Benefits for hospital care of the mother are covered at 90% of the Allowable Expense, after Deductible.

Out-of-Network. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

- 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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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.

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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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:

- (1) **Routine Physical Examinations.** The Program will provide coverage for In-Network periodic adult routine physical examinations in accordance with the United States Task Force on Preventative Care. Specifically, for covered individuals a routine physical examination will be covered as follows:

18 and over – 1 visit per year

Domestic Network Benefits. Domestic Network Benefits are covered at 100% of the Allowable Expense.

In-Network Benefits. In-Network Benefits are covered at 100% of the Allowable Expense.

Out-of-Network Benefits. Out-of-Network Benefits are not covered.

- (2) **Well Child Visits and Immunizations.** The Program will provide coverage for In-Network 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 at ages: five days; three weeks; and 2, 4, 6, 9, 12, 15, 18, and 24 months. In addition, well child visits will be covered once every Calendar Year for ages 3 through 18. 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.

Age less than 1 year – 7 visits

1-2 years – 4 visits

2 years – 2 visits

3-18 years – 1 visit per year

Domestic Network Benefits. Domestic Network Benefits are covered at 100% of the Allowable Expense.

In-Network Benefits. In-Network Benefits are covered at 100% of the Allowable Expense.

Out-of-Network Benefits. Out-of-Network Benefits are not covered.

- (3) **Adult Immunizations.** The Program will provide coverage for adult immunizations when Medically necessary in accordance with prevailing medical standards.

Domestic Network Benefits. Domestic Network Benefits are covered at 100% of the Allowable Expense.

In-Network Benefits. In-Network Benefits are covered at 100% of the Allowable Expense.

Out-of-Network Benefits. Out-of-Network Benefits are not covered.

B. Other Health Services.

- (1) **Laboratory and Pathology Services.** The Program will provide coverage for diagnostic laboratory and pathology services.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

- (2) **Vision Examinations.** The Program will provide coverage for diagnostic eye examinations to determine disease or injury to the eye. The Program will also cover one routine eye examination provided by an Optometrist or Ophthalmologist per Member per Calendar Year. 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.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$30 Copayment.

In-Network. In-Network Benefits are subject to a \$60 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

- (3) **Routine Eyewear.** A \$60 allowance is available for each Member per Calendar Year for routine eyeglass lenses, and frames or one pair of contact lenses when prescribed by an Optometrist or Ophthalmologist and purchased during an eye examination. This allowance shall apply to either an In-Network or an Out-of-Network purchase. The Program will not provide any benefits for sunglasses, even if prescribed by your Optometrist or Ophthalmologist.

For Members up to age 19, any amounts in excess of the \$60 allowance described above will be covered at 5% Coinsurance, limited to once per Calendar Year. You must submit a paper claim for payment of amounts in excess of the \$60 allowance to Excellus BlueCross BlueShield.

- (4) **Hearing Examinations.** The Program will provide coverage for diagnostic hearing examinations to determine disease or injury to the ear. The Program will also cover one routine hearing examination per Member per Calendar Year.

Domestic Network Benefits. Domestic Network Benefits for routine hearing exams are subject to a \$30 Copayment. Domestic Network Benefits for diagnostic hearing exams are subject to a \$15 Copayment if services are rendered by a primary care physician or \$30 Copayment if services are rendered by a specialist.

In-Network Benefits. In-Network Benefits for routine hearing examinations are subject to a \$60 Copayment. In-Network Benefits for diagnostic hearing examinations are subject to a \$30 Copayment for services rendered by a primary care physician or \$60 Copayment for services rendered by a specialist.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

- (5) **Hearing Aids.** The Program will provide coverage for hearing aids that are Medically Necessary for Members up to age 19.

Domestic Network Benefits. Domestic Network Benefits are covered at 100% of the Allowable Expense.

In-Network Benefits. In-Network Benefits are covered at 100% of the Allowable Expense.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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

Domestic Network Benefits. Domestic Network Benefits are subject to a \$15 Copayment for services rendered by a primary care physician or \$30 Copayment for services rendered by a specialist.

In-Network Benefits. In-Network Benefits are subject to a \$30 Copayment for services rendered by a primary care physician or \$60 Copayment for services rendered by a specialist.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

- D. **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.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$15 Copayment for services rendered by a primary care physician or \$30 Copayment for services rendered by a specialist.

In-Network Benefits. In-Network Benefits are subject to a \$30 Copayment for services rendered by a primary care physician or \$60 Copayment for services rendered by a specialist.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

9. **Diagnostic 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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

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.

Domestic Network Benefits. Domestic Network Benefits for routine mammography screenings are covered at 100% of the Allowable Expense. Domestic Network Benefits for diagnostic mammography screenings are covered at 90% of the Allowable Expense, after Deductible.

In-Network. In-Network Benefits for routine mammography screenings are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic mammography screenings are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network. Out-of-Network routine mammography screenings are not covered. Out-of-Network-Benefits for diagnostic mammography screenings are covered at 60% of the Allowable Expense, after Deductible.

- 13. **Gynecological Services.** The Program will provide coverage, subject to the limitations stated below, for gynecology visits, including coverage for cervical cancer screenings and its precursor states each Calendar Year for women 18 years of age and older. 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. The Program's coverage for routine cervical cytology screenings under this Section and Section Six, Paragraph 7 is limited to two screenings per Calendar Year. Cervical cytology screening shall mean an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

Domestic Network Benefits. Domestic Network Benefits for two routine screenings are covered at 100% of the Allowable Expense. Domestic Network

Benefits for diagnostic gynecological visits are subject to a \$15 Copayment for services rendered by a primary care physician or \$30 Copayment for services rendered by a specialist.

In-Network Benefits. In-Network Benefits for two routine screenings are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic gynecological visits subject to a \$30 Copayment for services rendered by a primary care physician or \$60 Copayment for services rendered by a specialist.

Out-of-Network. Out-of-Network Benefits for routine gynecological visits are not covered. Out-of-Network Benefits for diagnostic gynecological visits are covered at 60% of the Allowable Expense, after Deductible.

14. **Screenings for Prostate Cancer.** The Program will provide coverage for In-Network routine and 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 routine prostate screenings shall be subject to the following limitations:

- A. **Men with a Prior History of Prostate Cancer.** The Program will provide coverage for routine 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 routine 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 50 Years of Age or Older.** The Program will provide coverage for one routine exam in each Calendar Year for men 50 years of age and older.

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

Domestic Network Benefits. Domestic Network Benefits for routine screenings for prostate cancer are covered at 100% of the Allowable Expense. Domestic Network Benefits for diagnostic screenings for prostate cancer are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits for routine screenings for prostate cancer are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic screenings for prostate cancer are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network. Out-of-Network Benefits for routine screenings for prostate cancer are not covered. Out-of-Network Benefits for diagnostic screenings for prostate cancer are covered at 60% of the Allowable Expense, after Deductible.

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.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$15 Copayment for services rendered by a primary care physician or \$30 Copayment for services rendered by a specialist.

In-Network Benefits. In-Network Benefits are subject to a \$30 Copayment for services rendered by a primary care physician or \$60 Copayment for services rendered by a specialist.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

16. **Mental Health Disorder Outpatient Services.** The Benefit Plan covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of Mental Health Disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; or a professional corporation or a university faculty practice corporation thereof.

The Benefit Plan does not cover:

- A. Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- B. Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by a governmental agency; or
- C. Services solely because they are ordered by a court.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$15 Copayment.

In-Network Benefits. In-Network Benefits are subject to a \$15 Copayment.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

17. **Substance Use Outpatient Services.** The Benefit Plan covers outpatient substance use services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of alcoholism, substance use and dependency, including methadone treatment. Such coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation.

The Benefit Plan also covers outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from alcoholism, substance use and dependency; and 2) and the person receiving, or in need of, treatment for alcoholism, substance use and dependency are both covered under this Benefit Plan. The payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$15 Copayment.

In-Network Benefits. In-Network Benefits are subject to a \$15 Copayment.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

18. **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.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$30 Copayment.

In-Network. In-Network Benefits are subject to a \$60 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

19. **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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

20. **Infertility Treatment Services.** The Program will provide coverage for Medically Necessary services for the diagnosis and treatment of infertility subject to the following conditions:

- A. **Infertility Defined.** For the purposes of this Paragraph, infertility has the meaning set forth in the regulations of the New York State Insurance Department. In general, infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse.
- B. **Coverage Provided for Individuals 21 to 44 Years of Age.** The benefits provided by this Paragraph are available only to Members covered under this

Program who are between the ages of 21 and 44 as of the date the services are rendered.

- C. **Coverage Only Provided for Appropriate Candidates.** Coverage under this Paragraph will only be provided to “Appropriate Candidates” within the age group described in Subparagraph B. An Appropriate Candidate is an individual determined to be an Appropriate Candidate by the treating physician, in accordance with the standards and guidelines established and adopted by the New York State Insurance Department by regulation.
- D. **Covered Services.** Subject to the other provisions of this Paragraph and the Program, benefits will be provided under this Paragraph for:
- (1) Medical and surgical procedures, such as artificial insemination, intrauterine insemination, and dilation and curettage (“D&C”), that would correct malformation, disease, or dysfunction resulting in infertility;
 - (2) Services in relation to diagnostic tests and procedures necessary:
 - (a) To determine infertility; or
 - (b) In connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered by this Paragraph are:
 - Hysterosalpingogram;
 - Hysteroscopy;
 - Endometrial biopsy;
 - Laparoscopy;
 - Sono-hysterogram;
 - Post-coital tests;
 - Testis biopsy;
 - Semen analysis;
 - Blood tests;
 - Ultrasound; and
 - Other Medically Necessary diagnostic tests and procedures, unless excluded by law.
- E. **Plan of Care Required.** All services covered under this Paragraph must be prescribed by a physician as part of a “plan of care.” The plan of care must be in writing, and must be available for review. Services or procedures that are inconsistent with or not included in the plan of care will not be covered.
- F. **Services Must be Received from Eligible Providers.** Services covered by this Paragraph must be received from “Eligible Providers” as determined by Excellus BlueCross BlueShield. In general, an Eligible Provider is defined as a health care

provider who meets the required training, experience, and other standards established and adopted by the American Society for Reproductive Medicine.

- G. **Excluded Services.** The Program will not pay benefits for any services related to or in connection with:
- In-Vitro Fertilization;
 - Gamete Intra-Fallopian Transfer (GIFT);
 - Zygote Intra-Fallopian Transfer (ZIFT);
 - Reversal of elective sterilizations, including vasectomies and tubal ligations;
 - Sex change procedures;
 - Cloning; or
 - Other procedures or categories of procedures excluded from coverage for insured products by statute.
- H. **Experimental Procedures Not Covered.** This Paragraph does not cover services or procedures that are determined to be experimental, according to standards and guidelines that are no less favorable than those established and adopted by the American Society for Reproductive Medicine.
- I. **Deductibles, Copayments, and Coinsurance.** The benefits of this Paragraph are subject to any applicable Deductible or Coinsurance provisions under this Section Nine for similar services. For example, any Deductible, Coinsurance or Copayment for Surgical Care under Paragraph 1 will also apply to surgical services under this Paragraph; any Deductible, Coinsurance or Copayment for Laboratory and Pathology Services under Paragraph 8 (B)(1) will also apply to laboratory and pathology services under this Paragraph; and any Deductible, Coinsurance or Copayment for x-ray and imaging procedures under Paragraph 9 will also apply to x-ray and imaging procedures under this Paragraph.
21. **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.

The Deductible, Coinsurance or Copayment applicable to any inpatient care benefit described in Section 5 or outpatient care benefit described in Section 6 will not apply to any elective sterilization of a female Member, rendered by an In-Network Provider,

which is considered a preventive service in accordance with the preventive services provision of Section Ten, Subparagraph 9.

22. **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.

Domestic Network Benefits. Domestic Network Benefits for routine bone density testing are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic bone density testing are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits for routine bone density testing are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic bone density testing are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits for routine bone density testing is not covered. Out-of-Network Benefits for diagnostic bone density testing are covered at 60% of the Allowable Expense, after Deductible.

23. **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. Both In-Network and Out-of-Network visits will be counted toward this 10-visit maximum.

Domestic Network Benefits. Domestic Network Benefits are subject to a \$30 Copayment.

In-Network Benefits. In-Network Benefits are subject to a \$60 Copayment.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

SECTION TEN - ADDITIONAL BENEFITS

1. **Autism Spectrum Disorder.** The Program will provide coverage for the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder:

- A. **Screening and Diagnosis.** Coverage will be provided for assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
- B. **Assistive Communication Devices.** Coverage will be provided for a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, coverage may be provided for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage will also be provided for software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. Excellus BlueCross BlueShield will determine whether the device should be purchased or rented.

Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered; however, coverage will be provided for one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member's current functional level. No coverage is provided for delivery or service charges or for routine maintenance or the additional cost of equipment or accessories that are not Medically Necessary.

- C. **Behavioral Health Treatment.** Counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual will be covered when provided by a licensed provider. Coverage for applied behavior analysis will also be covered when provided by an applied behavior analysis provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment

program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

- D. **Psychiatric and Psychological Care.** Coverage will be provided for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.
- E. **Therapeutic Care.** Coverage will be provided for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such providers are otherwise covered under the Program. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists or social workers under the Program.

The Program will not provide coverage for any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under New York State Education Law. You are responsible for any applicable Deductible, Coinsurance or Copayment provisions under the Program for similar services. For example, any Deductible, Coinsurance or Copayment that applies to physical therapy visits generally will also apply to physical therapy services covered under this section. Any Deductible, Coinsurance or Copayment that applies to physician medical services; specialist office visits will apply to assistive communication devices covered under this section.

For purposes of this section “autism spectrum disorder” means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

- 2. **Transsexual Surgery And Related Services.** The Program will provide coverage for Medically Necessary services or care related to 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. For the criteria used to determine whether or not services or care are Medically Necessary, please refer to the Gender Reassignment Surgery Medical Policy and the Behavioral Health Treatment for Gender Dysphoria Medical Policy located at: <https://www.excellusbcbs.com/wps/portal/xl/prv/pc/medpol/smp/>. To request a paper copy of these policies, please contact the customer service number on your identification card.

You are responsible for any applicable Deductible, Coinsurance or Copayment provisions under the Program for similar services. For example, any Deductible, Coinsurance or Copayment that applies to inpatient hospitalization will also apply to inpatient hospitalizations covered under this section. Any Deductible, Coinsurance or Copayment that applies to physician office visits will also apply to physician office visits covered under this section.

3. **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 In-Network 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 In-Network medical personnel upon a referral from your Professional Provider or Authorized Medical Personnel: certified diabetes nurse educator, certified nutritionist, certified dietician, registered dietitian, or other provider as required by law applicable to insured health benefits contracts. Such education must be provided in a group setting, when practicable.

Domestic Network Benefits. Domestic Network Benefits for diabetic education are subject to a \$15 Copayment. Domestic Network Benefits for diabetic supplies and insulin obtained through a retail provider are covered at 90% of the Allowable Expense for a 30-day supply (your cost share will never exceed \$15). Domestic Network Benefits for diabetic supplies and insulin purchased by mail order are covered at 90% of the Allowable Expense, after Deductible for a 90-day supply. Domestic Network Benefits for diabetic durable medical equipment are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits for diabetic education are subject to a \$30 Copayment. In-Network Benefits for diabetic supplies and insulin obtained through a retail provider are covered at 90% of the Allowable Expense for a 30-day supply (your cost share will never exceed \$15). In-Network Benefits for diabetic supplies and insulin purchased by mail order are covered at 90% of the Allowable Expense, after Deductible for a 90-day supply. In-Network Benefits for diabetic durable medical equipment is covered at 90% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits for diabetic supplies and insulin are not covered. Out-of-Network Benefits for diabetic education and diabetic durable medical equipment are covered at 60% of the Allowable Expense, after Deductible.

3. **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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

4. **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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

5. **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, but do not include foot orthotics. 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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

6. **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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network. Out-of-Network Benefits are covered at 60% of the Allowable Expense, after Deductible.

7. **Ambulance Service.** The Program will provide coverage for Medically Necessary water, ground 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.

The Program will pay for transportation by water or air ambulance if it is deemed Medically Necessary by Excellus BlueCross BlueShield's Medical Director.

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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 90% of the Allowable Expense, after the Domestic Network Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 90% of the Allowable Expense, after the Domestic Network Deductible.

8. **Individual Case Management.**

- A. **Alternative Benefits.** If you agree to participate and abide by Excellus BlueCross BlueShield's policies, in addition to benefits specified in this Booklet, the Program may provide, outside the terms described in this Booklet, benefits for services, for up to a 60-day period, furnished by any In-Network Provider pursuant to an alternative treatment plan developed by Excellus BlueCross BlueShield for a Member whose condition would otherwise require hospitalization.

The Program may provide such alternative benefits if and only for so long as Excellus BlueCross BlueShield determines, among other things, that the alternative services are Medically Necessary, cost-effective, and feasible, and that the total benefits paid for such services do not exceed the total benefits to which you would otherwise be entitled under this Program in the absence of alternative benefits.

If the Program elects to provide alternative benefits for a Member in one instance, it shall not obligate the Program to provide the same or similar benefits for any Member in any other instance where the alternative treatment is not Medically Necessary, cost-effective, and feasible, nor shall it be construed as a waiver of the right to administer the Program thereafter in strict accordance with the expressed terms described in this Booklet.

At the expiration of such 60-day period, you may apply in writing for a continuation of the alternative benefits and services being provided outside the terms described in this Booklet. Upon such application for renewal, Excellus BlueCross BlueShield will review the patient's condition and may agree on behalf of the Program to a renewal of such alternative benefits and services. Renewals must be in writing.

The alternative benefits you receive will be in lieu of the benefits the Program would normally provide to you under the Program ("the Program benefits") for the treatment of your condition. As a result, we may require you to agree to waive certain Program benefits in order to receive the alternative benefits agreed upon. You may return to utilization of Program benefits at any time upon prior written notice to Excellus BlueCross BlueShield. However, the Program benefits remaining available to you will be reduced in a manner that appropriately reflects the alternative benefits you used.

- B. **Appeals of Individual Case Management.** If Excellus BlueCross BlueShield denies a request for Individual Case Management, you or your Professional Provider may appeal by requesting a review of the original decision. Or, if benefits under an individual case management plan are terminated, you or your Professional Provider may appeal by requesting a review. The request for review may be in writing to:

Corporate Managed Care
165 Court Street
Rochester, NY 14647

Or, you may contact Excellus BlueCross BlueShield's Member Services Department at the phone number located on your identification card. Please see Section Seventeen, Paragraph 25 for a description of your right to appeal Excellus BlueCross BlueShield's decisions to the Group.

9. **Preventive Services Required by the Federal Patient Protection and Affordable Care Act.**

The Program will provide coverage for the preventive services identified below. To the extent such items and services are covered elsewhere under this booklet, any cost-sharing provisions that may apply will not apply to any In-Network Benefit.

- A. **Evidence-Based Preventive Services.** Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the USPSTF issued in 2002 will be considered the current recommendations until further guidance is issued by the USPSTF or the Health Resources and Services Administration (HRSA);
- B. **Routine Immunizations.** Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention with respect to the individual involved;
- C. **Prevention for Children.** With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA.
- D. **Prevention for Women.** With respect to women, such additional preventive care and screenings, not otherwise addressed by the USPSTF, as provided for in comprehensive guidelines supported by HRSA and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional

women's preventive services).

A list of the preventive services covered under this paragraph is available on the Excellus BlueCross BlueShield website at www.excellusbcbs.com, or will be mailed to you upon request. You may request the list by calling Excellus BlueCross BlueShield.

Domestic Network Benefits. Domestic Network Benefits are covered at 100% of the Allowable Expense. Cost-sharing may apply to covered services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

In-Network Benefits. In-Network Benefits are covered at 100% of the allowable Expense. Cost-sharing may apply to covered services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

Out-of-Network Benefits. Out-of-Network Benefits are not covered.

10. **Qualified Clinical Trial Expenses.** The Program will provide coverage for all health care items and services for a Member for the treatment of cancer or any other Life-Threatening Condition that is consistent with the standard of care for an individual with the Member's diagnosis; provided, such health care items and services would have been covered under the Program if the Member did not participate in the Qualified Clinical Trial. To be eligible for coverage, the Member must meet the requirements of a qualifying individual, as defined below.

For purposes of this section a "qualifying individual" means a Member who is eligible to participate in a Qualified Clinical Trial according to the trial protocol with respect to the treatment of cancer or other Life-Threatening Condition; and either: (A) the referring health care professional has concluded that the Member's participation in such trial would be appropriate based upon his or her diagnosis; or (B) the Member provides scientific information establishing that the Member's participation in such trial would be appropriate based upon his or her diagnosis.

Notwithstanding the above, Qualified Clinical Trial expenses do not include the following:

- A. the experimental or investigational item, device or service, itself;
- B. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

- C. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The benefits of this paragraph are subject to any applicable Deductible or Coinsurance provisions for similar services. For example, any Deductible, Coinsurance or Copayment for imaging covered under Section Six, Paragraph 3 will also apply to imaging covered under this Paragraph.

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 of an In-Network Provider or Out-of-Network Provider 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.**

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 60% 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.

Domestic Network Benefits. Domestic Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

In-Network Benefits. In-Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

Out-of-Network Benefits. Out-of-Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

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.

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.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.

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.

- G. **Tier One Drug.** A Prescription Drug, typically a Generic Drug, that is designated as a Tier One Drug.
- H. **Tier Two Drug.** A Brand Name Drug that is included in the Tier Two Drug list. Tier Two Drugs are selected for their effectiveness, utilization and cost. The Tier Two Drug list is always under review and subject to update. A copy can be obtained, upon request, by calling Excellus BlueCross BlueShield. A copy is also available at the following website www.excellusbcbs.com.
- I. **Tier Three Drug.** A Brand Name Drug that is not a Tier One Drug or a Tier Two Drug, and drugs that have an equivalent Generic Drug.

2. Pharmacy Benefits Provided.

A. Drugs from a Participating Retail Pharmacy.

- (1) If you have a prescription filled with a Tier One Drug, you must pay the pharmacy either a \$10 Copayment or the cost of the Tier One Drug, whichever is less, for each separate prescription or refill for that Tier One Drug. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or refill.
- (2) If you have a prescription filled with a Tier Two Drug, you must pay the pharmacy 20% Coinsurance (\$25 minimum; \$50 maximum) or the cost of the Tier Two Drug, whichever is less, for each separate prescription or refill for that Tier Two Drug. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or refill.
- (2) If you have a prescription filled with a Tier Three Drug, you must pay the pharmacy 30% Coinsurance (\$45 minimum; \$90 maximum) or the cost of the Tier Three Drug, whichever is less, for each separate prescription or refill for that Tier Three Drug. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or refill.

B. Drugs from a Participating Mail Order Pharmacy.

- (1) If you have a prescription filled with a Tier One Drug, you must pay the pharmacy either a \$25 Copayment or the cost of the Tier One Drug, whichever is less, for each separate prescription or refill for that Tier One Drug. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or refill.
- (2) If you have a prescription filled with a Tier Two Drug, you must pay the pharmacy either a 20% Coinsurance (\$62.50 minimum; \$125 maximum) or the cost of the Tier Two Drug, whichever is less, for each separate prescription or refill for that Tier Two Drug. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or refill.
- (3) If you have a prescription filled with a Tier Three Drug, you must pay the pharmacy 35% Coinsurance (\$112.50 minimum; \$225 maximum) or the cost of the Tier Three Drug, whichever is less, for each separate prescription or refill for that Tier Three Drug. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or refill.
- (4) The foregoing Copayment/Coinsurance is for a 90-day supply.

C. Drugs from a Non-Participating Pharmacy. No benefits will be provided for

Prescription 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 A 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 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.
- F. **Value-Based Benefit Program (Dx/Rx Discount).** If you have been identified by the Group as an Eligible Participant (as defined by the Group) in a School of Nursing/ HLC Personal Health Management Program, you are eligible for a discount on Prescription Drugs covered under this Program as described below:
1. Each time you, as an Eligible Participant in a Personal Health Management Program, fill a Prescription Drug at a Participating Pharmacy your Copayment/Coinsurance obligation under the Program will be reduced by \$10.
 2. For Diabetic Drugs that you, as an Eligible Participant in a School of Nursing/ HLC Personal Health Management Program obtain under the this Program, your Coinsurance obligation will be 11%.
 3. In order to take advantage of the discounts available in a School of Nursing/ HLC Personal Health Management Program, Eligible Participants must have their prescriptions filled at a Participating Pharmacy.

The Value-Based Benefit Program (DX/Rx Discount) is only available at the following two Participating Pharmacies:

1. Strong Memorial Hospital Outpatient Pharmacy, 601 Elmwood Avenue, Rochester NY (NAPB 3357731); and
2. Strong Ties Outpatient Pharmacy, 2613 W. Henrietta Road, Rochester, NY (NAPB 3347639)

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 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 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 30-day supply of a drug purchased at a retail Participating Pharmacy or a 90-day supply dispensed by a mail order

Participating Pharmacy, inclusive of the University of Rochester Medical Center (URMC) Employee Pharmacy.

- C. 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/Coinsurance for the non-prescription drug will be based on the Tier One, Tier Two, or Tier Three Copayment/Coinsurance. 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 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, when they are available free of charge in the local area, except the Program will provide coverage for blood required for the treatment of hemophilia when billed by a Facility. When not free in the local area, the Program will cover blood charges, even if you donate or store your own blood, if billed by a Facility, ambulatory surgery center, or a certified blood bank.
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, as provided in Section Nine.
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. The Program will also provide the benefits set forth in this Booklet for service and care that Excellus BlueCross BlueShield determines in its sole judgment is Medically Necessary for treatment due to a congenital disease or anomaly. For purposes of this paragraph, "congenital" means the disease or anomaly is present and its symptoms or characterizations are evident and observable at birth. The Program will also cover services for treatment of TMJ following diagnosis of TMJ. The Program will also provide coverage for services that Excellus BlueCross BlueShield determines in its sole judgment are Medically Necessary for the treatment of cleft palate and ectodermal dysplasia. The Program will cover institutional provider services for dental care when Excellus BlueCross BlueShield determines there is an underlying medical condition requiring these services. Covered services will be covered in the same manner as similar services. For example, a covered office visit will be covered the same as a medical office visit and a Medically Necessary and covered crown will be covered as an external prosthetic.
8. **Developmental Delay.** The Program will not provide coverage for any service or care related to the educational treatment of behavioral disorders together with services for remedial education, including evaluation or treatment of learning disabilities, minimal

brain dysfunction, development and learning disorders, behavioral training, and cognitive rehabilitation. This exclusion applies to services, treatment, or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language, to instruct a Member whose ability to speak has been lost or impaired to function without that ability, is not covered.

9. **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 will not apply to Qualified Clinical Trial expenses and 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).

- 10. **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.
- 11. **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.

12. **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.

13. **Hypnosis/Biofeedback.** The Program will not provide coverage for hypnosis or biofeedback.
14. **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.
15. **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.
16. **Non-Covered Service.** 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; even when an In-Network Provider considers the service or care to be Medically Necessary and appropriate.
17. **Nutritional Therapy.** The Program will not provide coverage for any service or care related to nutritional therapy, unless it is determined that it is Medically Necessary or that it qualifies as diabetes self-management education. The Program will not provide coverage for commercial weight loss programs or other programs with dietary supplements.
18. **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.
19. **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.
20. **Reproductive Procedures.** The Program will not provide coverage for any service or care related to or in connection with: in-vitro fertilization, gamete intra-fallopian transfer

(GIFT), zygote intra-fallopian transfer (ZIFT), cloning, sperm banking and donor fees associated with artificial insemination or other procedures, or other procedures or categories of procedures excluded by statute as applicable to insured health benefits contracts.

21. **Reversal Of Elective Sterilization.** The Program will not provide coverage for any service or care related to the reversal of elective sterilization, unless Medically Necessary.
22. **Routine Care Of The Feet.** The Program will not provide coverage for services related to routine care of the feet, including but not limited to corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, toenails, or symptomatic complaints of the feet.
23. **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.
24. **Services Covered Under Hospice Care.** If you have been formally admitted to a hospice program and the Program is providing coverage for your hospice care, the Program will not provide additional coverage for any services related to your terminal illness that have been or should be included in the payment to the hospice program for the care you receive. However, should you require services covered under this Program for a condition not covered under the hospice program, coverage will be available under this Program for those covered services.
25. **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.

26. **Smoking Cessation Programs.** The Program will not provide benefits for smoking cessation programs, unless otherwise required to be covered as a preventive service under Section Ten.
27. **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.

28. **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.
29. **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.
30. **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. The Program, however, will provide benefits for covered services related to Medically Necessary treatment of morbid obesity, where weight is at least twice the ideal amount specified for frame, age, height, and gender in the most recent generally-accepted life insurance tables.
31. **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. **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.** When this Program is secondary, its benefits will be reduced so that the total benefits payable under the other plan and this Program do not exceed your expenses for an item of service. However, this Program will not pay more than it would have paid if it was primary.

This Program uses a Maintenance of Benefits (MOB) methodology as an alternative to the standard 100% allowable expense approach to coordination of benefits. The intent of MOB is to pay benefits that will not exceed the normal level of benefits that would have been payable under the plan with the highest benefits.

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 make an intentional misrepresentation of a material fact or commit 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. On your death or the death of the employee or member of the Group. Your widow/widower and unmarried surviving dependents are eligible for coverage under a University Health Care Plan if the employee has met the age and service requirements to retire, or the employee was retired, or the employee had five or more years of service, but had not yet met the criteria to retire. In this instance, the surviving spouse or domestic partner and eligible dependent children remain eligible for a period of one year following your death.
 - E. Termination of the employee or member of the Group's marriage or domestic partnership. If the employee or member of the Group becomes divorced or there has been a termination of the domestic partnership, or the employee or member of the Group's marriage is annulled, coverage of the employee or member 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 the Group, and the Group 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, 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 or a 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 the Federal laws and, as applicable, 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**
 - A. **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 BlueShield 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.

Group shall be responsible for ensuring all ERISA requirements applicable to the Program are satisfied. These include, but are not limited to the following:

- plan document requirements under Section 402 of ERISA
- applicable reporting and disclosure requirements

Notwithstanding the foregoing, the Group has contracted with Excellus BlueCross BlueShield to perform certain services hereunder (including certain services to satisfy Group’s ERISA obligations, such as adjudicating medical claims) and Excellus BlueCross BlueShield shall perform, and is responsible for performing, all of its services hereunder in accordance with ERISA and other applicable laws.

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.** A grievance procedure has been established to resolve Member grievances. These procedures make sure that your 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. Appeals regarding those decisions are handled pursuant to paragraph 25. To initiate a grievance, just contact Excellus BlueCross BlueShield. Excellus BlueCross BlueShield keeps all requests and discussions confidential and it will take no discriminatory action because of your issue. Excellus BlueCross BlueShield has a process for both standard and expedited grievances, depending on the nature of your inquiry. It maintains a file 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 from when you received the decision you are asking Excellus BlueCross BlueShield to review to file the grievance.

When Excellus BlueCross BlueShield receives your grievance, it will mail an acknowledgment 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.

If your grievance is related to a pre-service claim (a request for a service or treatment that has not yet been received), Excellus BlueCross BlueShield will decide your grievance and notify you of its determination in writing within 15 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.

If your grievance is related to a post-service claim (a claim for a service or treatment that has already been provided), or related to a matter unrelated to a claim or request for service, Excellus BlueCross BlueShield will decide the grievance within 30 calendar days of receipt of your request.

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 for the determination and, if a clinical matter is involved, the clinical rationale, or a written statement that insufficient information was presented or available to reach a determination, and further appeal rights, if any. Excellus BlueCross 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 (“Medically Necessary”). This process is called Utilization Review (UR). 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 the 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 at Excellus BlueCross BlueShield’s office. 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 its receipt of the information or the end of the 48-hour time period. A claim or other matter is “urgent” if it could seriously jeopardize your life or health or the ability to regain maximum function; or if your provider determines it is urgent, it must be treated as such.

- B. **Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision. If additional information is needed, Excellus BlueCross BlueShield will request it within one business day. 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 the earlier of one business day of receipt of the information or, if Excellus BlueCross BlueShield does not receive the information, within 15 calendar days of the end of the 45-day time period.

For concurrent reviews that involve urgent matters, Excellus BlueCross BlueShield will make a determination and provide notice to you (or your designee) and your provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified above for prospective urgent claims.

If Excellus BlueCross BlueShield has approved a course of treatment, Excellus BlueCross BlueShield will not reduce or terminate the approved services unless you have been given enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

- 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, 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 Initial Adverse Determination.** A notice of adverse determination (notice that a service is not Medically Necessary or is experimental/investigational) will include the reasons, including clinical criteria and clinical rationale, for Excellus BlueCross BlueShield's determination, date of service, provider name, and claim amount (if applicable). The notice will indicate that the diagnosis code and treatment code, and corresponding meaning of these codes, are available upon request. The notice will also advise you of your right to appeal the determination, and give instructions for requesting a standard or expedited internal appeal and initiating an external appeal. The notice will 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 and an explanation of why the information is necessary. The notice will also refer to the plan provision on which the denial is based. Excellus BlueCross BlueShield will send notices of determination to you (or your designee) and, as appropriate, to your health care provider.

- E. **Internal Appeals of Adverse Determinations.** You, your designee, and/or 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 review 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, your 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 or an external 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 Excellus BlueCross BlueShield's decision. It will also explain your rights to an external appeal. Notices of determination will be sent to you or your designee and to your health care provider.
- G. **Your Right to an Immediate External Appeal.** If Excellus BlueCross BlueShield fails to adhere to the utilization review requirements described above, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external appeal as described in paragraph 26 below. However, you will not be deemed to have exhausted the internal process if Excellus BlueCross BlueShield makes a minor error which is beyond its control or due to good cause, is made in the context of an ongoing good faith exchange of information and does not reflect a pattern or practice of non-compliance.

26. **External Appeal.**

- A. **External Appeal in General.** You have the right to an “external appeal” of certain coverage determinations made by Excellus BlueCross BlueShield. An external appeal is a request for an independent review of a coverage determination by a third party known as an Independent Review Organization (IRO). IROs must be accredited by a nationally-recognized accrediting organization and must be assigned to review appeals pursuant to independent, unbiased selection methods. “Requested service” or “requested services” refers to the service or services for which you are requesting coverage. You may request an external appeal only if the requested service is covered by the Program.

You may have the right to an expedited external appeal if the timeframe for completion of an expedited internal appeal or a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function. Also, you have the right to an expedited external appeal in connection with final adverse determinations concerning an admission, availability of care, continued stays, or health care services for which you received emergency services, but have not been discharged from a facility. If coverage is denied on the basis that the requested service is experimental or investigational, and your treating physician certifies that the requested service would be significantly less effective if not promptly initiated, you may request an expedited external appeal. The timeframes for determining expedited external appeals are shorter than the timeframes for standard external appeals.

- B. **Coverage Determinations Subject to External Appeal.** This subparagraph describes the general conditions for external appeal.

In general, you may not request an external appeal unless Excellus BlueCross BlueShield has issued a “final adverse determination” of your request for coverage through the first level of the internal appeal process. However, if you qualify for an expedited external appeal, you may also file an expedited external appeal at the same time as filing an expedited internal appeal. You are also eligible for an external appeal if both parties have agreed to an external appeal even though you have not obtained a final adverse determination.

To be eligible for external appeal, the final adverse determination issued through the first level of the internal appeal process must be based on a determination that the requested service does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or that the requested service is experimental or investigational or for a retroactive termination of coverage. You do not have the right to an external appeal of any other determinations, even if those other determinations affect your coverage.

- C. **Requesting an External Appeal.** If you meet the conditions described above,

you or your authorized representative may request an external appeal by completing and filing a self-insured external appeal application with Excellus BlueCross BlueShield. Excellus BlueCross BlueShield will send the external appeal application to you with the notice of final adverse determination. You or your authorized representative will have the opportunity to submit additional information on the requested service; and you may be required to authorize the release of any medical records needed to reach a decision on the external appeal.

You must file your request for an external appeal with Excellus BlueCross BlueShield within four months of receiving a final adverse determination.

Upon receipt of a request for an external appeal, Excellus BlueCross BlueShield must determine if the request meets the requirements for external review and will notify you of its eligibility determination. Upon a determination that the request is eligible for external review, Excellus BlueCross BlueShield will assign the appeal to an IRO for review.

- D. **Effect of the IRO's Decision.** The IRO's decision on your external appeal is binding on both parties, except to the extent other remedies are available under state or federal law.
- E. **Questions.** If you do not understand any part of the external appeal process or if you have questions regarding your right to external appeal, you may contact the Employee Benefits Security Administration at 1-866-444-3272.