

These are your

## **University of Rochester**

### **PREFERRED PROVIDER ORGANIZATION BENEFITS**

#### **University PPO Plan**

#### **2021 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 Booklet is part of the plan document and summary plan description.

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

**Domestic Network 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. **Acute.** The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.
- B. **Allowable Expense.** The Allowable Expense means the maximum amount the Program will pay for the services or supplies covered under this Program, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. The Allowable Expense is determined as follows:

The Allowable Expense for In-Network Providers will be the amount the Program has negotiated with the In-Network Provider, or the amount approved by another Blue Cross and/or Blue Shield plan, or the In-Network Provider's charge, if less. However, when the In-Network Provider's charge is less than the amount the Program has negotiated with the In-Network Provider, your Copayment, Deductible or Coinsurance amount will be based on the In-Network Provider's charge.

The Allowable Expense for Out-of-Network Providers will be determined as follows:

(1) **Facilities in the Excellus BlueCross BlueShield Service Area.**

For Facilities in the Service Area, the Allowable Expense will be 80% of the Centers for Medicare and Medicaid Services Prospective Payment System ("CMSPPS") amount unadjusted for geographic locality, or the Facility's charge, if less.

In the event the Program is unable to price the services at the CMSPPS rate because of insufficient claims data or there is no CMSPPS rate, the Allowable Expense will be 80% of the average amount the Program has negotiated with Facilities that are In-Network Providers of the same type as the Out-of-Network Facility.

(2) **Facilities Outside the Excellus BlueCross BlueShield Service Area.**

For Facilities outside the Service Area, the Allowable Expense will be 100% of the average amount the Program has negotiated with Facilities that are In-Network Providers of the same type as the Out-of-Network Facility, or the Facility's charge, if less.

(3) **For a Health Care Professional or a Provider of Additional Health Services in the Excellus BlueCross BlueShield Service Area.**

For a Health Care Professional or a Provider of Additional Health Services in the Service Area, the Allowable Expense will be 80% of the Centers for Medicare and Medicaid Services Provider ("CMMSP") fee schedule, as

applicable to the provider type unadjusted for geographic locality, or the Health Care Professional or Provider of Additional Health Services charge, if less.

If there is no CMMSP amount as described above, the Allowable Expense will be 75% of the Health Care Professional or Provider of Additional Health Services charge.

- (4) **For a Health Care Professional or a Provider of Additional Health Services Outside the Excellus BlueCross BlueShield Service Area.** For a Health Care Professional or a Provider of Additional Health Services outside the Service Area, the Allowable Expense will be 150% of the Centers for Medicare and Medicaid Services Provider (“CMMSP”) fee schedule, as applicable to the provider type unadjusted for geographic locality, or the Health Care Professional or Provider of Additional Health Services charge, if less.

If there is no CMMSP amount as described above, the Allowable Expense will be 75% of the Health Care Professional or Provider of Additional Health Services charge.

- (5) **Emergency Services.** The Allowable Expense for an Out-of-Network Provider for Emergency Services will be the Out-of-Network Provider’s charge. You are responsible for any Domestic Network Deductible or Coinsurance.
- (6) **Physician-Administered Pharmaceuticals.** For Physician-administered pharmaceuticals, the Program uses gap methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or Excellus BlueCross BlueShield based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.
- (7) **In Vitro Diagnostic Test for the Detection of SARS-CoV-2.** Effective as of March 13, 2020, the Allowed Amount for an Out-of-Network Provider for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 is the Out-of-Network Provider’s publicly listed price for such test, or such lower rate as Excellus BlueCross BlueShield may negotiate with the Out-of-Network Provider.

**The Out-of-Network Provider's actual charge may exceed the Program's Allowable Expense. You must pay the difference between the Allowable Expense and the Out-of-Network Provider's charge. Contact Excellus BlueCross BlueShield at the number on your ID card or visit the Excellus BlueCross BlueShield website for information on your financial responsibility when you receive services from an Out-of-Network Provider.**

The Program reserves the right to negotiate a lower rate with Out-of-Network Providers or to pay a Blue Cross and/or Blue Shield host plan's rate, if lower.

- 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.** The percentage of the fee that the Program pays for certain health care services once a Member has satisfied his or her Deductible.
- 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. **Essential Health Benefit.** An Essential Health Benefit has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act. Essential Health Benefits include the following general categories and the items and services covered within such categories: ambulatory patient services; Emergency Services; Hospitalization; maternity and newborn care; mental health and substance use services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic and disease management; and pediatric services, including oral and vision care.

The determination of what benefits constitute an Essential Health Benefit under this Program will be made in accordance with the benchmark plan for the state of Utah.
- M. **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.

N. **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) Infirmarys 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.

O. **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. You will be responsible for paying an annual Deductible as well as a Copayment or a Coinsurance amount on many covered services.

P. **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.

- Q. **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.
- R. **Lifetime Maximum.** The maximum benefit payable during an individual's lifetime while covered under this Program. This Program may provide for a Lifetime Maximum benefit for a specific type of covered service or treatment.
- S. **Medical Director.** The person designated by Excellus BlueCross BlueShield to monitor quality of care and appropriate utilization of health services.
- T. **Medical Necessity.** See Section Three of this Booklet.
- U. **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.
- V. **Mental Health Disorder.** A Mental Health Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.
- W. **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.
- X. **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.
- Y. **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.
- Z. **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; nurse practitioner; physician assistant; 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.

- AA. **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.
- BB. **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.
- CC. **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.

- DD. **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.
- EE. **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.
- FF. **Substance Use Disorder.** A Substance Use Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.
- GG. **“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 residents, fellows, 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.

Generally speaking, other employees such as students, per diems, temporary employees, and any employee with a Time-as-Reported (TAR) appointment are not eligible for health care options, unless they qualify as a full-time employee in accordance with the Group's Measurement and Stability Periods Policy. If you have a TAR appointment and are eligible for health care coverage through the Group, your coverage will be effective per the guidelines in the Group's Measurement and Stability Periods Policy.

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 "Certification of Domestic Partner Status" form and Health Program Guide.

The value of the Program 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.

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 60 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 60 days of the birth, coverage of the child, except for the first 48 hours (vaginal delivery) or 96 hours (cesarean section) after birth, 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, except for the first 48 hours (vaginal deliver) or 96 hours (cesarean section) after birth, 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 2 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 6 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 6 below. **Any**

**changes requested during the annual open enrollment period, will be effective the following January 1; 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 60 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.
6. **Making Benefit Changes Outside of the Open Enrollment Period.** You can only enroll in or change your coverage under the Program during the year if you experience a change that is considered a qualifying event. **Changes due to a qualifying event must be received by the Group within 60 days of the qualifying event and will be retroactive. If you do not return a completed election form and the requested documentation within the 60-day period described above, you will not be able to make any changes until the next annual open enrollment period or unless you experience another qualifying event. Any changes requested during the annual open enrollment period, will be effective the following January 1.**

You have the opportunity to change your benefits if:

- A. **You get married.** You may enroll or add coverage for your spouse and any newly eligible dependents. You may also change coverage to another Program option. You may also discontinue coverage for yourself and any dependents that gain coverage under your spouse's plan. Any changes become effective as of the date of the event.
- B. **Your Domestic Partner becomes eligible for benefits.** You may add coverage for your Domestic Partner and any newly eligible dependents to your current Program option on an after-tax basis if you are already enrolled for coverage. You may discontinue coverage for any dependents who were receiving coverage on an after-tax basis that gain coverage under your Domestic Partner's plan. Any changes become effective as of the date of the event.
- C. **You get divorced or your marriage is annulled.** You must discontinue coverage for your former spouse and any dependents that become ineligible (e.g. stepchildren), and you may remove any dependents that will be added to your former spouse's plan. You may enroll or add coverage for yourself or any eligible dependents that are no longer covered under your former spouse's plan. You also may change coverage to another Program option. Any changes become effective as of the event. Any claims incurred on or after the date of divorce/annulment by the former spouse will not be paid for by the Program. If you are adding or removing eligible dependents the changes become effective as of the date of the event. You may add coverage for any eligible dependents that are no longer eligible for coverage under your former spouse's plan or for whom

you are required to provide coverage pursuant to a Qualified Medical Child Support Order.

- D. **You end a Domestic Partnership.** You must discontinue coverage for your former Domestic Partner and any dependents that become ineligible (e.g., partner's children). You may enroll if you lost coverage under your former Domestic Partner's plan. You may add coverage for any eligible dependents that are no longer eligible for coverage under your former Domestic Partner's plan or for whom you are required to provide coverage pursuant to a Qualified Medical Child Support Order. If your Domestic Partner (or his or her child) was your tax dependent, then you also may change coverage to another Program option. Any changes become effective as of the date of the event. Any claims incurred on or after the date of the Termination of Domestic Partnership not be paid for by the Program. If you are adding or removing eligible dependents any changes become effective as of the date of the event.
- E. **Your eligible dependent passes away.** You may drop the deceased from coverage. You may enroll or add coverage for yourself or any eligible surviving dependents that are no longer covered under the deceased's plan. You also may change coverage to another Program option. Any changes become effective the date of the event.
- F. **You have a new child (by birth, adoption, or placement for adoption).** You may enroll or add coverage for your spouse or Domestic Partner and any newly eligible dependents. You also may change coverage to another Program option. Any changes become effective as of the date of birth/adoption/placement for adoption of the new child.
- G. **Your dependent is no longer eligible for benefits under the Program (e.g. child reached the age at which coverage is no longer available).** You must discontinue coverage for your ineligible spouse, domestic partner or dependent. Any changes become effective as of the date of the event.
- H. **You experience a change in employment status that impacted your eligibility for benefits (e.g. retirement, commencing or returning from a leave of absence in excess of 30 days, termination of employment, transfer to the University from another affiliated employer).** If you have become newly eligible you may enroll for coverage. If you are no longer eligible your coverage is cancelled effective on the last date of the pay period in which you lost eligibility. COBRA coverage may be available to you and your eligible dependents. If you retire, you may change or drop your coverage under the Program. If you continue coverage, your premiums will be paid on an after-tax basis. COBRA coverage may be available to you and your eligible dependents. If you are newly eligible any changes become effective the date of the event.

- I. **Your eligible dependent experiences a qualifying election change event under his or her own employer's cafeteria plan (e.g. change in employment status, HIPAA special enrollment right, significant cost increase or curtailment of coverage, etc.).** You may make a corresponding change permitted by Cafeteria Plan tax regulations, as determined by the Benefits Office. Any changes become effective as of the date of the event.
- J. **You become enrolled as an adult child under your parent's employer group health plan during an annual open enrollment period, HIPAA special enrollment period or as a result of your parent experiencing a qualifying election change event under his or her own employer's Cafeteria Plan.** You may discontinue coverage under the Program. Any changes become effective as of the date of the event.
- K. **You or your former spouse is required to provide coverage for a dependent by legal judgment or court order (e.g. Qualified Medical Child Support Order).** You may enroll and add coverage for your eligible dependent if the order requires you to provide coverage. You may also change coverage to another Program option. Any changes become effective as of the date required by court order or date is determined by the Plan Administrator to be qualified, whichever is later.
- L. **You, your current or former spouse (or his or her child) who is a tax dependent, or current Domestic Partner (or his or her child) who is a tax dependent, changes coverage from another employer's plan during their employer's open enrollment period that is different than the University's open enrollment period.** You may enroll or add coverage for your affected spouse, domestic partner, and eligible dependents who lose coverage under the Program. You also may change coverage to another Program option. You may discontinue coverage for yourself and any dependents that gain coverage through the other employer's plan. Any changes become effective as of the date of the event.
- M. **Your current Domestic Partner (or his or her child) who is not a tax dependent, changes coverage from another employer's plan during their employer's open enrollment period that is different than the University's open enrollment period.** You may add coverage for your affected Domestic Partner and eligible dependents on an after-tax basis. You may discontinue coverage for any dependents who were receiving Program coverage on an after-tax basis that gain coverage through the other employer's plan. Any changes become effective as of the date of the event.
- N. **You or your eligible dependents lose eligibility for other employer group health plan coverage, governmental health insurance, nongovernmental health insurance through no fault of your own, exhaust COBRA coverage, or another employer ceases contributions toward health insurance for your or**



**your eligible dependents.** You may enroll for coverage for yourself, your spouse, your Domestic Partner, or your children who were affected. You also may change coverage to another Program option. Any changes become effective as of the date of the event.

- O. **You start or return from FMLA leave or military leave.** If you start FMLA leave or military leave, you may cancel your coverage or you may continue your coverage. If you elected to cancel your coverage during FMLA leave or military leave, upon returning from such leave, you may reinstate your prior coverage. If you have experienced another election change event while on a leave or have been on leave in excess of 30 days, you may make an election change in accordance with the rules for that event. Any changes become effective as of the date of the event. If you elect to continue coverage during FMLA leave, your coverage will be continued during the length of your FMLA and in accordance with the same terms and conditions as if you were an active employee. Please refer to the Group's policies and procedures regarding continuation of coverage under this Program during FMLA leave. If you continue coverage during your military leave, your coverage will be continued for the first 30 days of your leave in accordance with the same terms and conditions as if you were an active employee. If you elect to continue coverage beyond the first 30 days of leave, your coverage will be continued in accordance with COBRA and USERRA. Please refer to the Group's policies and procedures regarding continuation of coverage under this Program during military leave.
- P. **You or your eligible dependents enroll in Medicaid or Medicare.** You may continue coverage or cancel or reduce coverage for the individual who is enrolled in Medicaid or Medicare. Any changes become effective as of the date of the event.
- Q. **You or your eligible dependents lose entitlement to Medicaid or a state children's health insurance program.** Enroll or increase coverage for yourself, your spouse, your Domestic Partner, or your children (whomever lost the entitlement). You also may change coverage to another Program option. Any changes become effective as of the date of the event.
- R. **You or your eligible dependents enroll in or lose coverage in a Qualified Health Plan (QHP) through a public health insurance exchange/marketplace.** You may cancel coverage for the individual(s) who is enrolled in (or intends to enroll in) QHP coverage. QHP coverage must be effective immediately following cancellation of coverage under the Program. No change is permitted if you or your dependents lose QHP coverage.
- S. **You experience a significant cost change (as determined by the University) in the premium for medical coverage.** **Cost Increase:** You may change coverage to another Program option or discontinue coverage if you elect coverage through another employer's plan. **Cost Decrease:** You may elect new coverage or

change coverage to another plan. Any changes become effective as of the date of the event.

## 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 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. **Temporary Suspension of Preauthorization Requirements.** Effective as of March 20, 2020, the Program will suspend, for 90 days (unless it is extended by future regulations or guidance), any:

- (a) preauthorization requirements that may apply to schedule surgeries or admissions at a Hospital;
- (b) concurrent review for inpatient Hospital services;
- (c) retrospective review for inpatient Hospital services and Emergency Services rendered by a participating provider; and
- (d) preauthorization requirements for home health care and inpatient rehabilitation services following an inpatient Hospital stay.

Effective as of April 22, 2020, the Program will suspend until June 18, 2020 (unless it is extended by future regulations or guidance), any:

- (a) preauthorization requirements for all services provided at a Hospital;
- (b) concurrent review for all services provided at a Hospital;
- (c) retrospective review for all services provided at a Hospital.

However, the Program reserves the right to retrospectively review services provided at a Hospital upon the expiration of this provision if it has evidence that a Hospital is engaging in fraudulent or abusive billing practices. In the event this provision is extended by future regulations or guidance, the Program is automatically amended to comply.

6. **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.
7. **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.

8. **Transition of Care.** If you are pregnant when your Domestic Network Provider leaves the network or you have a baby that is in the neonatal unit of the University of Rochester Medical Center and your baby is transferred to Rochester General Hospital because of capacity issues, then you or your baby (as applicable) will continue to receive covered services at the Domestic Network Provider level of benefits. If you are pregnant you will continue to receive Domestic Network Provider level benefits for the remainder of your pregnancy, including delivery and any postpartum care directly related to the delivery. If your baby is transferred to the neonatal unit of Rochester General Hospital, your baby will continue to receive covered services at the Domestic Network Provider level of benefits until the baby is discharged.

You will be responsible only for any applicable Deductible, Copayments or Coinsurance that applies to Domestic Network Benefits.

If you are pregnant and continue to receive covered services with a former Domestic Network Provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the Program's relationship with the provider. The provider must also agree to provide the Program any necessary medical information related to your care and adhere to the Program's policies and procedures, including those for assuring quality of care, obtaining preauthorization and a treatment plan approved by the Program. If the provider agrees to these conditions, you will receive the covered services as if they were being provided by a Domestic Network Provider. If the provider was terminated by the Program due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the provider's ability to practice continued treatment with that provider is not available.

## 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 \$500 (Domestic Network Providers); \$1,250 (In-Network Providers); and \$3,000 (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 \$1,250 (Domestic Network Providers); \$3,125 (In-Network Providers); or \$9,000 (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. When an individual in a family meets the individual Deductible (described above), no further Deductible will be required for services for that person covered under the Program for the remainder of the 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").**

*For full-time employees that earn less than \$60,000 per year (this amount is revised annually and included in the Health Program Guide), your Out-of-Pocket Maximum is as follows: When you have paid \$2,000 (Domestic Network Providers); \$3,000*

(In-Network Providers); or \$5,000 (Out-of-Network Providers) for services covered under this Program for Deductibles, Coinsurance and 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); \$5,500 (In-Network Providers); or \$10,000 (Out-of-Network Providers) for Deductibles, Coinsurance and 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. When an individual in a family meets the individual Out-of-Pocket Maximum (described above), the Program will provide coverage for 100% of the Allowable Expense for covered services for that person 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.

- A. *For full-time employees that earn more than \$60,000 per year (this amount is revised annually and included in the Health Program Guide), your Out-of-Pocket Maximum is as follows:* When you have paid \$2,750 (Domestic Network Providers); \$4,250 (In-Network Providers); or \$6,500 (Out-of-Network Providers) for services covered under this Program for Deductibles, Coinsurance and 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 you have other than individual coverage, once a person within a family has paid \$2,750 (Domestic Network Providers), \$4,250 (In-Network Providers), or \$6,500 (Out-of-Network Providers) the Program will provide coverage for 100% of the Allowable Expense for the rest of that Calendar Year for that person.

If other than individual coverage applies, when members of the same family covered under the Program have paid an aggregate of \$5,500 (Domestic Network Providers); \$8,500 (In-Network Providers); or \$13,000 (Out-of-Network Providers) for Deductibles, Coinsurance and 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. When an individual in a family meets the individual Out-of-Pocket Maximum (described above), the Program will provide coverage for 100% of the Allowable Expense for covered services for that person 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.

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. You will remain responsible for any charges of an Out-of-Network Provider that are in excess of the Allowable Expense.



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 carry over 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 \$3,000 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 \$5,000 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; or
  - F. Custodial care (See Section Fourteen).
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 Program 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 Program. 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. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Excellus BlueCross BlueShield.

The Program 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 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Law Article 30; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Excellus BlueCross BlueShield, and that provide (at a minimum) those services and treatments identified in the most recent McKesson InterQual criteria for a psychiatric residential treatment center or in such other comparable criteria recognized by the Excellus BlueCross BlueShield.

- C. **Substance Use Inpatient Services.** The Program covers inpatient substance use services relating to the diagnosis and treatment of Substance Use Disorders. 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 Program also covers inpatient substance use services relating to the diagnosis and treatment of Substance Use Disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by 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 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 for up to 120 days per Calendar Year for a condition that in the judgment of your provider and the Medical Director can reasonably be expected to result in significant improvement within a relatively short period of time. 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.

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.

All of the Group's health care plans cover mastectomies and related procedures (subject to any applicable deductibles, coinsurance or copays). Under federal law, all group health plans that provide coverage for medical and surgical benefits with respect to a mastectomy must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage

includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Group health plans may impose deductible or coinsurance requirements for reconstructive surgery in connection with a mastectomy, but only if the deductible and coinsurance are consistent with those established for other benefits under the plan or coverage.

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. Treatment of infertility is not an Essential Health Benefit and services related to in vitro fertilization are subject to a Lifetime Maximum of \$30,000 per Member, including any prescription drugs. In-Network Benefits and Out-of-Network Benefits both count towards the Lifetime Maximum Benefit of \$30,000.
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.

**In-Network Benefits.** In-Network Benefits for inpatient care subject to this Section, other than inpatient mental health or substance use services, are covered at 75% of the Allowable Expense, after Deductible. In-Network Benefits for inpatient mental health services are covered at 90% of the Allowable Expense, after Deductible. In-Network Benefits for inpatient substance use services are covered at 90% of the Allowable Expense, after the Domestic Network Deductible.

**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.

## 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 75% 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 75% 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 routine and 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 for routine procedures are covered at 100% of the Allowable Expense. Domestic Network Benefits for diagnostic procedures are covered at 90% of the Allowable Expense, after Deductible.

**In-Network Benefits.** In-Network Benefits for routine procedures are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic procedures are covered at 75% of the Allowable Expense, after Deductible.

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

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

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

**In-Network Benefits.** In-Network Benefits for routine services are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic services are covered at 75% of the Allowable Expense, after Deductible.

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

5. **Radiation Therapy And Chemotherapy.** The Program will provide coverage for radiation therapy and chemotherapy. Orally-administered anti-cancer drugs are covered under the Prescription Drug Benefits section of this 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 75% 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 **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 75% 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. **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.** The Program covers mammograms for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, the Program covers mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be covered.

Diagnostic mammograms (mammograms that are performed in connection with the diagnosis of breast cancer) are unlimited and are covered whenever they are Medically Necessary.

The Program also covers additional screening and diagnostic imaging, including breast ultrasounds and MRIs, for the detection of breast cancer.

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

**In-Network Benefits.** In-Network Benefits for routine mammograms are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic mammograms are covered at 75% 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.



8. **Colonoscopy.** The Program provides coverage for colonoscopies to screen for colon cancer in asymptomatic Members in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from the USPSTF.

Diagnostic colonoscopies (colonoscopies that are performed in connection with the treatment or follow-up of colon cancer) are covered whenever they are Medically Necessary.

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

**In-Network Benefits.** In-Network Benefits for routine colonoscopies are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic colonoscopies are covered at 75% of the Allowable Expense, after Deductible.

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

9. **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. The Program’s coverage for routine cervical cytology screenings under this Section and Section Nine 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 75% 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.

10. **Mental Health Disorder Outpatient Services.** The Program 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; a licensed mental health counselor; a psychiatric nurse, licensed as a nurse practitioner; a licensed marriage and family therapist; or a professional corporation or a university faculty practice corporation thereof.

**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 60% of the Allowable Expense, after Deductible.

11. **Substance Use Outpatient Services.** The Program 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 Program 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 Program. 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 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 60% of the Allowable Expense, after Deductible.

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

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 and in the outpatient department of a Facility pursuant to this Section are subject to the 45-visit limit.

**Domestic Network Benefits.** Domestic Network Benefits are subject to a \$35 Copayment.

**In-Network Benefits.** In-Network Benefits are subject to a \$65 Copayment.

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

13. **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 75% 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. **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 75% of the Allowable Expense, after Deductible.

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

15. **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 75% of the Allowable Expense, after Deductible.

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

16. **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.

You are responsible for any applicable Deductible or Coinsurance provisions under this Section for similar services.

Treatment of infertility is not an Essential Health Benefit and services related to in vitro fertilization are subject to a Lifetime Maximum of \$30,000 per Member, including any prescription drugs. In-Network Benefits and Out-of-Network Benefits both count towards the Lifetime Maximum Benefit of \$30,000.

17. **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.

## 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 75% 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 hospice 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 75% 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, elective termination of pregnancy, 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 75% 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 75% 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 covered at 90% of the Allowable Expense, after Deductible.

**In-Network Benefits.** In-Network Benefits are covered at 75% 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. **Covered Therapies.** The Program will provide coverage for related rehabilitative physical therapy and physical, occupational and speech therapy when services are rendered by a licensed physical therapist, occupational therapist, or speech language pathologist or audiologist and when 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.

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 and in a Professional Provider's office pursuant to this Section are subject to the 45-visit limit.

**Domestic Network Benefits.** Domestic Network Benefits are subject to a \$35 Copayment.

**In-Network Benefits.** In-Network Benefits are subject to a \$65 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 75% 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 \$20 Copayment if services are rendered by a primary care physician or \$35 Copayment if services are rendered by a specialist.

**In-Network Benefits.** In-Network Benefits are subject to a \$35 Copayment if services are rendered by a primary care physician or \$65 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 \$20 Copayment if services are rendered by a primary care physician or \$35 Copayment if services are rendered by a specialist.

**In-Network Benefits.** In-Network Benefits are subject to a \$35 Copayment if services are rendered by a primary care physician or \$65 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.

**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 75% 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.

**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 75% 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 75% of the Allowable Expense, after Deductible.

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

D. **Routine Newborn Nursery Care.** The Program will provide coverage for routine newborn nursery 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 75% 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 for services other than mental health and substance use are covered at 75% of the Allowable Expense, after

Deductible. In-Network Benefits for mental health and substance use services are covered at 90% 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 Health Services and Resources Administration (HRSA). 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 Health Services and Resources Administration (HRSA). 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 in accordance with the recommendations of the Advisory Committee on Immunization Practices of the CDC.

**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 routine and diagnostic laboratory and pathology services.

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

**In-Network Benefits.** In-Network Benefits for routine services are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic services are covered at 75% of the Allowable Expense, after Deductible.

**Out-of-Network Benefits.** Out-of-Network Benefits for routine services are not covered. Out-of-Network Benefits for diagnostic services 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. .

**Domestic Network Benefits.** Domestic Network Benefits are subject to a \$20 Copayment if services are rendered by a primary care physician or a \$35 Copayment if services are rendered by a specialist.

**In-Network.** In-Network Benefits are subject to a \$35 Copayment if services are rendered by a primary care specialist or a \$65 Copayment if services are rendered by a specialist.

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

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

**Domestic Network Benefits.** Domestic Network Benefits are subject to a \$35 Copayment.

**In-Network Benefits.** In-Network Benefits are subject to a \$65 Copayment.

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

- (4) **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 up to a maximum of \$600 every three (3) Plan Years.

**In-Network Benefits.** In-Network Benefits are covered at 100% of the Allowable Expense up to a maximum of \$600 every three (3) Plan Years.

**Out-of-Network Benefits.** Out-of-Network Benefits are covered at 100% of the Allowable Expense up to a maximum of \$600 every three (3) Plan Years.

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

**Domestic Network Benefits.** Domestic Network Benefits are subject to a \$20 Copayment for services rendered by a primary care physician or \$35 Copayment for services rendered by a specialist.

**In-Network Benefits.** In-Network Benefits are subject to a \$35 Copayment for services rendered by a primary care physician or \$65 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 \$20 Copayment for services rendered by a primary care physician or \$35 Copayment for services rendered by a specialist.

**In-Network Benefits.** In-Network Benefits are subject to a \$35 Copayment for services rendered by a primary care physician or \$65 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 75% 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. Orally-administered anti-cancer drugs are covered under the Prescription Drug Benefits section of this 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 75% 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 75% 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. **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.** The Program covers mammograms for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, the Program covers mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be covered.

Diagnostic mammograms (mammograms that are performed in connection with the diagnosis of breast cancer) are unlimited and are covered whenever they are Medically Necessary.

The Program also covers additional screening and diagnostic imaging, including breast ultrasounds and MRIs, for the detection of breast cancer.

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

**In-Network Benefits.** In-Network Benefits for routine mammograms are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic mammograms are covered at 75% 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. **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 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 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 \$20 Copayment for services rendered by a primary care physician or \$35 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 \$35 Copayment for services rendered by a primary care physician or \$65 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. **Colonoscopy.** The Program provides coverage for colonoscopies to screen for colon cancer in asymptomatic Members in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from the USPSTF.

Diagnostic colonoscopies (colonoscopies that are performed in connection with the treatment or follow-up of colon cancer) are covered whenever they are Medically Necessary.

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

**In-Network Benefits.** In-Network Benefits for routine colonoscopies are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic colonoscopies are covered at 75% of the Allowable Expense, after Deductible.

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

15. **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 75% 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.

16. **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 for allergy testing are subject to a \$20 Copayment for services rendered by a primary care physician or \$35 Copayment for services rendered by a specialist. Domestic Network Benefits for allergy treatment are covered at 100% of the Allowable Expense.

**In-Network Benefits.** In-Network Benefits for allergy testing are subject to a \$35 Copayment for services rendered by a primary care physician or \$65 Copayment for services rendered by a specialist. In-Network Benefits for allergy treatment 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.

17. **Mental Health Disorder Outpatient Services.** The Program 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.

**Domestic Network Benefits.** Domestic Network Benefits are subject to a \$20 Copayment.

**In-Network Benefits.** In-Network Benefits are subject to a \$20 Copayment.

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

18. **Substance Use Outpatient Services.** The Program 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 Program 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 Program. 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 \$20 Copayment.

**In-Network Benefits.** In-Network Benefits are subject to a \$20 Copayment.

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

19. **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 \$35 Copayment.

**In-Network.** In-Network Benefits are subject to a \$65 Copayment.

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

20. **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 for services other than mental health and substance use are covered at 75% of the Allowable Expense, after Deductible. In-Network Benefits for mental health and substance use services are covered at 90% of the Allowable Expense, after Deductible.

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

21. **Infertility Treatment Services.** Infertility treatment services are not an Essential Health Benefit. The Program will provide coverage for the diagnosis and treatment (surgical and medical) of infertility. “Infertility” is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member’s medical history or physical findings.
- (A) **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. Infertility is determined in accordance with the standards and guidelines established and



adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine.

Basic infertility services include:

- I. Initial evaluation;
- II. Blood tests;
- III. Endometrial biopsy;
- IV. Evaluation of ovulatory function;
- V. Hysterosalpingogram;
- VI. Laboratory evaluation;
- VII. Medically appropriate treatment of ovulatory dysfunction;
- VIII. Pelvic ultrasound;
- IX. Postcoital test;
- X. Semen analysis;
- XI. Sono-hystogram; and
- XII. Testis biopsy.

Additional tests may be Covered if the tests are determined to be Medically Necessary.

- (B) **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, the Program will provide coverage for comprehensive infertility services. Comprehensive infertility services include:
- I. Artificial insemination;
  - II. Hysteroscopy;
  - III. Laparoscopy;
  - IV. Laparotomy;
  - V. Ovulation induction and monitoring; and
  - VI. Pelvic ultrasound.
- (C) **Advanced Infertility Services.** The Program covers in vitro fertilization up to a Lifetime Maximum of \$30,000 per Member, including any Prescriptions Drugs. In-Network Benefits and Out-of-Network Benefits both count towards the Lifetime Maximum Benefit of \$30,000.
- (D) **Fertility Preservation Services.** The Program covers standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. “Iatrogenic infertility” means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

All services must be provided by providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

- (F) **Cost-Sharing.** The benefits of this section are subject to any applicable Coinsurance, Copayment or Deductible provisions under this Program for similar services. In addition, services related to in vitro fertilization are subject to a Lifetime Maximum of \$30,000 per Member, including any prescription drugs. In-Network Benefits and Out-of-Network Benefits both count towards the Lifetime Maximum Benefit of \$30,000.

22. **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 10.

23. **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 of 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 75% 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.

24. **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 \$35 Copayment.

**In-Network Benefits.** In-Network Benefits are subject to a \$65 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.

You are responsible for any applicable Deductible, Coinsurance or Copayment provisions under the Program for similar services.

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 \$20 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 for a 90-day supply (your cost share will never exceed \$15). 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 \$35 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 for a 90-day supply (your cost share will never exceed \$15). In-Network Benefits for diabetic durable medical equipment is covered at 75% 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. **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 75% 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. **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 75% 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. **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 75% 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.

7. **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 75% of the Allowable Expense, after Deductible.

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

8. **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.

9. **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 for a description of your right to appeal Excellus BlueCross BlueShield's decisions to the Group.

10. **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).
- E. **COVID-19 Vaccine:** Effective as of 15 business days after a recommendation is made from the United States Preventive Services Task Force or CDC Advisory Committee on Immunization Practices, the Program will provide coverage for vaccines and other services intended to prevent COVID-19.

A list of the preventive services covered under this paragraph is available on the Excellus BlueCross BlueShield website at [www.excellusbcbbs.com](http://www.excellusbcbbs.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, other than prenatal care or family planning that is considered a preventive service, are not covered. Out-of-Network Benefits for prenatal care and family planning that is considered a preventive service are covered at 60% of the Allowable Expense, after Deductible.

11. **Smoking Cessation.** The Program will provide coverage for smoking cessation in accordance with the preventive services provision above.

**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.

12. **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 will also apply to imaging covered under this Paragraph.

13. **Biofeedback.** The Program will provide coverage for biofeedback.

**Domestic Network Benefits.** Domestic Network Benefits are subject to a \$20 Copayment if services are rendered by a primary care physician or \$35 Copayment if services are rendered by a specialist.

**In-Network Benefits.** In-Network Benefits are subject to a \$35 Copayment if services are rendered by a primary care physician or a \$65 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.

14. **In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19.** Effective as of March 13, 2020, and during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), or until such other date determined to be appropriate by the Employer, the Program will provide coverage for an in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such a test for members suspected of a COVID-19 infection, or suspected of having recovered from COVID-19 infection, that—
- (a) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb—

3);

- (b) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;
- (c) is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID–19; or
- (d) other tests that the Secretary determines appropriate in guidance.

Such test must have been determined to be medically appropriate for you by your attending provider. In addition to the above, the Program will provide coverage for any items and services provided during an office visit (including telehealth), urgent care center visit, or emergency room visit that relates to the furnishing or administration of the test or to the evaluation of the individual for purposes of determining the need for the test; and results in an order for or administration of such test. Such coverage will be provided when rendered by an In-Network Provider or Out-of-Network Provider and will not be subject to any cost-sharing (i.e. Coinsurance, Copayments or Deductibles), preauthorization requirements or any other medical management requirements. Other services that you may receive during such a visit that are not related to determining the need for a test or administration of a test, will be subject to the normal Program cost-sharing, preauthorization and medical management requirements.

## 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 the Domestic Network Deductible.



**Out-of-Network Benefits.** The Allowable Expense for an Out-of-Network Provider for Emergency Services will be the Out-of-Network Provider's charge. You are responsible for any *Domestic Network* Deductible or Coinsurance.

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 75% 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. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Program. This list is subject to periodic review and modification (no more than four (4) times per calendar year or when a Brand-Name Drug becomes available as a Generic Drug). To determine which tier a particular Prescription Drug has been assigned visit the Claim Administrator’s website at [www.excellusbcbs.com](http://www.excellusbcbs.com) or call the number on your ID card.
  - C. **Generic Drug.** A Prescription Drug that is manufactured, approved, and marketed under an Abbreviated New Drug Application (ANDA).
  - D. **Negotiated Rate.** The rate of payment agreed to between the Participating Pharmacy and Excellus BlueCross BlueShield for Prescription Drugs covered under this Program.
  - E. **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.**
  - F. **Participating Pharmacy.** Any pharmacy that regularly dispenses Prescription Drugs and has entered into a participation agreement with Excellus BlueCross BlueShield.
  - G. **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 include, but are not limited to:

- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- 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](http://www.excellusbcbs.com), or that will be mailed to you upon request. You may request the Formulary by calling the number shown on your ID card.
- 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.
- Prescription contraceptive drugs and devices (including “over-the-counter contraceptive products”), or their generic equivalents, approved by the

federal food and drug administration. The drug or device must be prescribed by Professional Provider who is legally authorized to prescribe drugs (or otherwise authorized under applicable law). “Over-the-counter contraceptive products” means those products provided for in comprehensive guidelines supported by HRSA. The Program will also cover contraceptive devices administered by a Professional Provider. These contraceptive devices include but are not limited to: diaphragms; IUDs; contraceptive implants, such as Norplant; and contraceptive injections such as Depo-Provera. They are covered as a service of the Professional Provider who administers them. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by your attending provider. All of the limitations and restrictions that are applicable to your Prescription Drug benefit also apply to this benefit.

- H. **Tier One Drug.** A Prescription Drug, typically a Generic Drug, that is designated as a Tier One Drug.
- I. **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](http://www.excellusbcbs.com).
- J. **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.**

*Specialty drugs are not available at a retail pharmacy. Please see the specialty drug section below. Prescription drugs for services related to in vitro fertilization are subject to a Lifetime Maximum of \$30,000 per Member, including any medical services rendered. Prescription drugs for the treatment of infertility are not an Essential Health Benefit.*

- (1) **Tier One Drug** (other than contraceptives). If you have a prescription filled with a Tier One Drug, you must pay the pharmacy either a \$15 Copayment or the cost of the Tier One Drug, whichever is less, for each separate prescription or refill for that Tier One Drug.
- (2) **Tier Two Drug** (other than contraceptives). If you have a prescription

filled with a Tier Two Drug, you must pay the pharmacy 20% Coinsurance (\$25 minimum; \$60 maximum) or the cost of the Tier Two Drug, whichever is less, for each separate prescription or refill for that Tier Two Drug.

- (3) **Tier Three Drug** (other than contraceptives). If you have a prescription filled with a Tier Three Drug, you must pay the pharmacy 35% Coinsurance (\$50 minimum; \$120 maximum) or the cost of the Tier Three Drug, whichever is less, for each separate prescription or refill for that Tier Three Drug. Effective prior to 05/01/2021, if your Tier Three Drug is for prescription insulin, you must pay the pharmacy 35% Coinsurance (\$50 minimum; \$100 maximum) or the cost of the Tier Three Drug, whichever is less, for each separate prescription or refill for that Tier Three Drug.
- (4) **Contraceptive, Drugs, Devices and other Contraceptive Products.** All contraceptive drugs, devices and other contraceptive products that are included on the Formulary are covered by the Program at 100% of the cost of such drug, device or product. You may request a copy of the Formulary, free of charge, by calling the customer service number on your ID card. You may also view the Formulary by visiting the Claim Administrator's website at [www.excellusbcbs.com](http://www.excellusbcbs.com)
- (5) The foregoing Copayment/Coinsurance (if any) is for a 30-day supply.

**B. Drugs from a Participating Mail Order Pharmacy.**

*Specialty drugs are not available at a mail order pharmacy. Please see the specialty drug section below. Prescription drugs for services related to in vitro fertilization are subject to a Lifetime Maximum of \$30,000 per Member, including any medical services rendered. Prescription drugs for the treatment of infertility are not an Essential Health Benefit.*

- (1) **Tier One Drug** (other than contraceptives). If you have a prescription filled with a Tier One Drug, you must pay the pharmacy either a \$37.50 Copayment or the cost of the Tier One Drug, whichever is less, for each separate prescription or refill for that Tier One Drug. Effective as of 05/01/2021, if your Tier One Drug is for prescription insulin, you must pay the pharmacy either a \$37.50 Copayment or the cost of the prescription insulin, whichever is less, for up to a 90 day supply.
- (2) **Tier Two Drug** (other than contraceptives). If you have a prescription filled with a Tier Two Drug, you must pay the pharmacy either a 20% Coinsurance (\$62.50 minimum; \$150 maximum) or the cost of the Tier Two Drug, whichever is less, for each separate prescription or refill for that Tier Two Drug.

- (3) **Tier Three Drug** (other than contraceptives). If you have a prescription filled with a Tier Three Drug, you must pay the pharmacy 35% Coinsurance (\$125.00 minimum; \$300 maximum) or the cost of the Tier Three Drug, whichever is less, for each separate prescription or refill for that Tier Three Drug.
- (4) **Contraceptive, Drugs, Devices and other Contraceptive Products.** All contraceptive drugs, devices and other contraceptive products that are included on the Formulary are covered by the Program at 100% of the cost of such drug, device or product. You may request a copy of the Formulary, free of charge, by calling the customer service number on your ID card. You may also view the Formulary by visiting the Claim Administrator's website at [www.excellusbcbs.com](http://www.excellusbcbs.com)
- (5) The foregoing Copayment/Coinsurance (if any) is for a 90-day supply.

C. **Specialty Drugs.** Specialty drugs are only covered under this Program if they are filled at the University of Rochester Employee Pharmacy. Specialty drugs filled outside of the University of Rochester Employee Pharmacy will not be covered and you will be responsible for the full cost of the drug. Such cost will not apply to your Deductible or Out-of-Pocket Maximum.

The University of Rochester Employee Pharmacy is dedicated exclusively to UR employees, volunteers, non-Medicare eligible retirees, and eligible dependents. The pharmacy features potential savings for employees and their families who are covered under this Program. If you have a specialty drug filled at the University of Rochester Employee Pharmacy your Copayment, as specified under section A (for a 30-day supply) or section B (for a 90-day supply) above, will be reduced by 25%. In addition, you will receive a 90-day supply of any maintenance medications and free delivery of any medication if you are an off-site employee.

For additional information on the University of Rochester Employee Pharmacy, including instructions on how to transfer any existing prescriptions, please visit [www.urmc.rochester.edu/pharmacy/pharmacies/employee.aspx](http://www.urmc.rochester.edu/pharmacy/pharmacies/employee.aspx).

**SaveonSP Program.** For certain specialty drugs, you must confirm your enrollment in the SaveonSP program ("Saveon") by calling 1-800-683-1074. If you confirm your enrollment in Saveon your Copayment for the specialty drugs will be waived. Specialty drugs available through Saveon are considered non-Essential Health Benefits. Specialty drugs available through the Program are subject to the Copayment that is set by Saveon and can be found by visiting the following website: <http://www.saveonsp.com/wp-content/uploads/2018/11/ExcellusPreferredValueFormulary.pdf>. A paper copy can be requested, free of charge, by calling the telephone number on your ID card. If you fail to confirm your enrollment in the Program, you will be responsible for



the Copayment that applies to retail Prescription Drugs listed in 2A above and not the Copayment set by Saveon and such Copayment will not count toward satisfaction of your Deductible or your Out-of-Pocket Maximum. If you are not eligible for Saveon, you will be responsible for the Copayment that applies to retail Prescription Drugs listed in the 2A above and not the Copayment set by Saveon and such Copayment will count toward your Out-of-Pocket Limit.

- D. **Drugs from a Non-Participating Pharmacy. No benefits will be provided for Prescription Drugs that you purchase at a Non-Participating Pharmacy.**
- E. **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.
- F. **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.
- G. **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 available at any Participating Pharmacy.

H. **Contraceptive Supply Limits.** You may have the entire prescribed supply (of up to 12 months) of the contraceptive drug or device dispensed at the same time. Contraceptive drugs and devices are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Pharmacy.

I. **Emergency Supply of Prescription Drugs for Substance Use Disorder Treatment.** If you have an Emergency Condition (as defined below), you may immediately access, without preauthorization, a five (5) day emergency supply of a Prescription Drug for the treatment of a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. If you have a Copayment, it will be the same Copayment that would apply to a 30-day supply of the Prescription Drug. If you receive an additional supply of the Prescription Drug within the 30-day period in which you received the emergency supply, you will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.

In this paragraph, “Emergency Condition” means a substance use disorder condition that manifests itself by Acute symptoms of sufficient severity, including severe pain or the expectation of severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- 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;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

J. **Initial Limited Supply of Prescription Opioid Drugs.** If you receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and you have a Copayment, your Copayment will be the same Copayment that would apply to a 30-day supply of the Prescription Drug. If you receive an additional supply of the Prescription Drug within the same 30-day period in which you received the seven (7) day supply, you will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.

### 3. **Limitations.**

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

- (1) **Prior Authorization.** Certain Prescription Drugs will only be filled with prior authorization from Excellus BlueCross BlueShield. The Prescription Drugs that require prior authorization are identified based

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

- (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 Seventeen of this Program.

- (c) **Failure to Seek Authorization.** When you fail to seek a required prior authorization of a Prescription Drug and the drug is dispensed, you must pay the Participating Pharmacy the total cost of the drug. If you then submit a claim, and Excellus BlueCross BlueShield determines that the Prescription Drug is Medically Necessary, the Program will pay only 50% of the amount it would otherwise have paid for the Prescription Drug. If Excellus BlueCross BlueShield determines that the Prescription Drug is not Medically Necessary, no benefits will be provided for the Prescription Drug and you will be responsible for the entire charge.
  - (2) **Step Therapy Program.** The Step Therapy Program is a form of prior authorization under which certain Prescription Drugs require prior authorization if a Generic Drug or cost-effective alternative Prescription Drug has not been tried. The Prescription Drugs that require prior authorization under the Step Therapy Program are also included on the form entitled “Prescription Drugs Requiring Prior Authorization” that is given to you with this Program. In addition, these Prescription Drugs are identified on the Formulary that is available at [www.excellusbcbs.com](http://www.excellusbcbs.com) or that will be mailed to you upon request. You may request the Formulary by calling the number shown on your ID card.
  - (3) **Prescription Drugs that Receive FDA Approval.** Prior authorization or step therapy applies to all new drugs entering the market upon FDA approval. The new drugs will be added to the Prior Authorization and Step Therapy Drug List until Excellus BlueCross BlueShield determines that the new drug satisfies the criteria for safety, efficacy and cost-effectiveness.
  - (4) **Other Changes.** The Program may add or change 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.

- D. **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 or via the internet at [www.excellusbcbs.com](http://www.excellusbcbs.com).
  - 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 10 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 10. 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 treatment of infertility not otherwise covered by this Program. In addition, fertility drugs with respect to services for in vitro fertilization are subject to a Lifetime Maximum of \$30,000 per Member.
- L. Over-the-Counter (OTC) products and prescription medications that have exact OTC equivalents are not covered under this Program. If a prescription product is

available in the identical strength, dosage form and active ingredient(s) as an OTC product, the prescription product is not covered under this Program.

**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. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of your medical condition (including both physical and mental health conditions).
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. **Eye surgery (concerning refractive errors).** The Program will not provide coverage for eye surgery concerning refractive errors.
9. **Eyewear and Routine Eye Exams.** The Program will not provide coverage for eyewear or routine eye examinations.
10. **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).

- 11. **Foot Orthotics.** The Program will not provide coverage for foot orthotics.
- 12. **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, domestic Partner 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.

13. **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.
14. **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.

15. **Hearing Aids.** The Program will not provide coverage for hearing aids for Members age 19 or older.
16. **Hypnosis.** The Program will not provide coverage for hypnosis.
17. **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.
18. **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.
19. **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.
20. **Non-Emergency Condition.** The Program will not provide coverage for emergency room services for a non-Emergency Condition.
21. **Not Medically Necessary.** The Program will not provide coverage for any service or care this is not Medically Necessary.
22. **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.

23. **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.
24. **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.
25. **Reproductive Procedures.** The Program will not provide coverage for any service or care related to or in connection with: Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; costs associated with an ovum or sperm donor, including the donor's medical expenses; cryopreservation and storage of sperm and ova except when performed as fertility preservation services; cryopreservation and storage of embryos; ovulation predictor kits; reversal of tubal ligations; costs for and relating to surrogate motherhood (maternity services are covered for Members acting as surrogate mothers); cloning; or medical and surgical procedures that are experimental or investigational.
26. **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.
27. **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.
28. **School System Services.** The Program will not provide coverage for any covered services that are available under or covered or provided by an individualized education plan (IEP) or an early intervention program (EIP) or any similar program that is mandated by law or that any school system or state or local government is required to provide under any law; this applies even if the Member, parent or guardian does not seek such services under an available program or plan. This exclusion does not apply to otherwise covered services that exceed the recommendations of or which are not available through the IEP, EIP or other program.
29. **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.
30. **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.

31. **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.

32. **Special Charges.** The Program will not provide coverage for charges billed to you for telephone consultations (except telemedicine and telehealth services covered in accordance with the Excellus BlueCross BlueShield telemedicine and telehealth medical policy), 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.
33. **Social Counseling And Therapy.** The Program will not provide coverage for any service or care related to family, marital, religious, or other social counseling or therapy, except as otherwise explicitly provided in this Booklet.
34. **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.
35. **Weight Loss Services.** The Program will not provide coverage for any service or care in connection with weight reduction or dietary control, that is determined to be medically inappropriate for treatment of obesity, or weight loss, including, but not limited to, gastric stapling, gastric by-pass, gastric bubble, or other related 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 obesity.
36. **Wigs.** The Program will not provide coverage for wigs.

37. **Work Related Illness or Injury.** The Program will not provide coverage for any service or care due to a work related illness or injury.
38. **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 - GENERAL PROVISIONS

1. **No Assignment.** our right to receive benefits or payments under this Program may not be assigned, voluntarily or involuntarily, to any other person, corporation or other entity. Any assignment by you will be void. A direct payment by the Program to a person or entity that provides medical services to a Program participant is not a waiver of this provision. A medical service provider may not bring a claim for benefits or payments against the Program, a Program fiduciary, or the Group with respect to the services it provides to a Program participant.
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. **Claim and Appeal Procedures, including External Review.** For the claim and appeal procedures under this Program, including your right to external review, please refer to the Health Program Guide.

6. **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.
7. **Statute of Limitations and Exhaustion of Administrative Remedies.** You may not commence a judicial proceeding against any person, including the Program, a Program fiduciary, the Plan Administrator, the Group, Claims Reviewer, Excellus BlueCross BlueShield, or any other person, with respect to a claim for benefits without first exhausting the claims procedures set forth in this Program. If you have exhausted these procedures and are dissatisfied with the decision on appeal of a denied claim you may bring an action under Section 502 of ERISA in the United States District Court for the Western District of New York, to review the Claims Reviewer's decision on appeal, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the Claims Reviewer's decision on appeal. Civil actions cannot be brought in any other federal or state court.
6. **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.
7. **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.
8. **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.
9. **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. Excellus BlueCross BlueShield has full discretionary authority to interpret the Program and make all decisions with respect to claims for benefits that are payable under the Program.
10. **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.

11. **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.
12. **Changes In This Program.** The Group may unilaterally change this Program at any time.
13. **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.
14. **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.
15. **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.
16. **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.

17. **Right to Develop Guidelines and Administrative Rules.** Excellus BlueCross Blue Shield and/or the Group may develop or adopt standards which describe in more detail when payments will or will not be made under this Program. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether emergency care in the outpatient department of a Facility was necessary; or whether certain services are Skilled Care. Those standards will not be contrary to the descriptions in this Booklet. If you have a question about the standards which apply to a particular benefit, you may contact Excellus BlueCross BlueShield or the Group and the standards will be explained or sent to you. Excellus BlueCross BlueShield and/or the Group may also develop administrative rules pertaining to enrollment and other administrative matters. Excellus BlueCross BlueShield and the Group shall have all the powers necessary or appropriate to carry out their respective duties in connection with the administration of this Program.
18. **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.

19. **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. **Services will not be Denied Based on Gender Identity.** The Program will not limit coverage or impose additional cost sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the gender for which such health services are ordinarily available. In such cases, the Program generally will rely on recommendations of the treating physician, Excellus BlueCross BlueShield medical policies, and applicable legal guidance to determine if a particular service is medically appropriate.

26. **Temporary Tolling of Certain Timeframes.**

Effective as of March 1, 2020, the Program will disregard days occurring during the "Outbreak Period" (as defined below), for purposes of determining the date by which an individual (e.g., a participant, claimant, dependent, qualified beneficiary) has to:

- (a) request mid-year enrollment in medical coverage due to a HIPAA special enrollment event where the special enrollment period otherwise would include any day of the Outbreak Period;
- (b) elect to initially enroll in COBRA continuation coverage if the 60-day initial election period otherwise would include any day of the Outbreak Period;
- (c) make an initial or any subsequent COBRA premium payment if the time period (or the grace period) for making the COBRA premium payment otherwise would include any day of the Outbreak Period;
- (d) provide a required notice to the Program of a COBRA qualifying event, if the time period for providing the notice otherwise would include any day of the Outbreak Period;
- (e) file an initial claim for benefits under the Program if the timely filing period otherwise would include any day of the Outbreak Period;

- (f) file an internal or external appeal (if applicable) in response to an adverse benefit determination if the time period for filing an internal or external appeal otherwise would include any day of the Outbreak Period; or
- (g) perfect a request for external review (if applicable) in response to a notice that the request is not complete if the time period for perfecting the request otherwise would include any day of the Outbreak Period.

In all cases where a time period referred to in (a)-(g) above began before March 1, 2020, in determining the extended time period based on the above rule, any period of time prior to March 1, 2020 will be subtracted from the time period that would apply without the extension to determine the remaining time frame in which a Member has to act after the end of the Outbreak Period. For example, for a special enrollment request that is subject to a 30-day special enrollment period, if the special enrollment period started on February 15, 2020, (i) the period from February 15 through February 29 will count as the first 14 days of the 30-day period (leaving 16 days in the special enrollment period), (ii) the entire Outbreak Period (March 1, 2020 through February 28, 2021) will be disregarded and (iii) the special enrollment period will end 16 days after the end of the Outbreak Period, on March 16, 2021.

Coverage with respect to (b) and (d) above, may be retroactive to the date of the qualifying event; provided the Member makes any required premium payments prior to the end of the extended time period provided for above.

For purposes of this section, the “Outbreak Period” is the period beginning on the later of (1) March 1, 2020 or (2) the “Applicable Event Date” (as defined below) and ending on the earlier of (A) one year from the Applicable Event Date or (B) 60 days after the announced end of the “National Emergency” described in the next sentence (or on a different date announced by the Internal Revenue Service and the Employee Benefits Security Administration (the “Agencies”)) and will be interpreted to be consistent with the meaning of that term under the Notice issued by the Agencies and published in the Federal Register on May 4, 2020 (and any subsequent guidance from the Agencies). The “National Emergency” for this purpose is the National Emergency declared on March 13, 2020 (with a March 1, 2020 effective date) as a result of the COVID-19 outbreak. If the National Emergency is determined by the Agencies to end on different dates in different parts of the country, the Outbreak Period with respect to a specific event or all events, if applicable, will be interpreted to end on the date that is determined by the Program Administrator to be appropriate for the Program. In no case will the Outbreak Period for any event last longer than one year or begin before March 1, 2020 or after the date described in (B) above.

For purposes of this section, the “Applicable Event Date” is determined under the following chart, based on which event (from events (a) through (g) above) has occurred:

Event	Event type	Applicable Event Date
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(a)	Special enrollment event	First day of special enrollment period
(b)	Initial COBRA election	First day of 60-day COBRA election period
(c)	Initial COBRA payment	First day of 45-day initial payment period
	Monthly COBRA payment	First day of 30-day payment grace period
(d)	COBRA qualifying event notice	First day of 60-day period for providing notice
(e)	Initial claim	Date of claim
(f)	Internal or external appeal	Date of receipt of claim denial
(g)	Perfection of external appeal	Date of receipt of notice of need for information

## **SECTION EIGHTEEN – NONDISCRIMINATION NOTICE**

### **Discrimination is Against the Law**

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

The Group:

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

If you need these services, contact the SMH Grievance Coordinator.

If you believe that the Group has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the SMH Grievance Coordinator, 601 Elmwood Avenue, Box 612, Rochester, NY 14642, phone: 585-275-0954, fax: 585-756-5584. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the SMH Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.