These are your

ONONDAGA COUNTY

MEDICAL BENEFITS PLAN

ONPOINT 25

2018

This Booklet explains your Onondaga County OnPoint 25 health benefits plan (the "Benefit Plan"). These benefits are sponsored and funded by Onondaga County (the "Group"). Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield ("Excellus BlueCross BlueShield" or the "Claims Administrator"), administers claims for benefits under the Benefit Plan 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 Benefit Plan offers you the option to receive covered services on two benefit levels:

In-Network Benefits. In-Network Benefits typically are the highest level of coverage available. In-Network Benefits apply when your care is provided by Participating Providers. Except in emergencies, you should always consider receiving health care services care first through the In-Network Benefits portion of this Benefit Plan. You will be responsible for paying Copayments on many covered services.

Out-of-Network Benefits. The Out-of-Network Benefits portion of this Benefit Plan covers health care services described in this Booklet when you choose to receive the covered services from Non-Participating 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 BENEFIT PLAN. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS BOOKLET.

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SECTION ONE - INTRODUCTION AND DEFINITIONS

1. **Your Coverage under this Benefit Plan.** The Group has created the self-funded Benefit Plan effective January 1, 2018, unless otherwise stated elsewhere in this document. Under the Benefit Plan, the benefits described in this booklet will be provided to employees of the Group and their covered family members, subject to the Group's eligibility requirements. You should keep this booklet with your other important papers so that it is available for your future reference.

2. **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 maximum amount the Benefit Plan will pay for the services or supplies covered under this Benefit Plan, before any applicable Coinsurance, Copayment, and Deductible amounts are subtracted. The Allowable Expense is determined as follows:

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

   The Allowable Expense for Non-Participating Providers will be determined as follows:

   (1) **Facilities in the 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 (MMSPPS) amount unadjusted for geographic locality, or the Facility's charge, if less.

   If there is no MMSPPS amount as described above, the Allowable Expense will be 75% of the Facility's charge.

   (2) **Facilities outside the Service Area.**
   For Facilities outside the Service Area, the Allowable Expense will be 150% of the Centers for Medicare and Medicaid Services Prospective Payment System (MMSPPS) amount unadjusted for geographic locality, or the Facility's charge, if less.

   If there is no MMSPPS amount as described above, the Allowable Expense will be 75% of the Facility's charge.

(3) **For a Professional Provider or a Provider of Additional Health Services in the Service Area.**
For a Professional Provider 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 fee schedule (CMS Fee Schedule), as applicable to the provider type, unadjusted for geographic locality, or the Professional Provider or a Provider of Additional Health Services' charge, if less.

If there is no CMS Fee Schedule amount as described above, the Allowable Expense will be 75% of the Professional Provider or a Provider of Additional Health Services' charge.

(4) **For a Professional Provider or a Provider of Additional Health Services Outside the Service Area.**
For a Professional Provider or a Provider of Additional Health Services in the Service Area, the Allowable Expense will be 150% of the Centers for Medicare and Medicaid Services Provider fee schedule (CMS Fee Schedule), as applicable to the provider type, unadjusted for geographic locality, or the Professional Provider or a Provider of Additional Health Services' charge, if less.

If there is no CMS Fee Schedule amount as described above, the Allowable Expense will be 75% of the Professional Provider or a Provider of Additional Health Services' charge.

(5) **Emergency Services.** The Allowable Expense for a Non-Participating Provider for Emergency Services will be the Non-Participating Provider's charge. You are responsible for any Coinsurance, Copayment or Deductible.

(6) **Physician-Administered Pharmaceuticals.**
For Physician-administered pharmaceuticals, the Benefit Plan 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 the Plan 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.

The Non-Participating Provider's actual charge may exceed the Allowable Expense. You must pay the difference between the Allowable Expense and

the Non-Participating Provider's charge. Contact the Claims Administrator at the number on your ID card or visit the Claims Administrator's website for information on your financial responsibility when you receive services from a Non-Participating Provider.

The Benefit Plan reserves the right to negotiate a lower rate with Non-Participating Providers or to pay a Blue Cross and/or Blue Shield host plan's rate, if lower.

C. **Brand Name** means a trade name medication.

D. **Calendar Year.** The twelve (12) month period beginning on January 1 and ending on December 31. However, if you were not covered under this Benefit Plan for this entire period, Calendar Year means the period from the date you became covered until December 31.

E. **Coinsurance.** A charge, expressed as a percentage of the Allowable Expense, that you must pay for certain services provided under this Benefit Plan. You are responsible for the payment of any Coinsurance directly to the provider.

F. **Copayment.** A predetermined charge, expressed as a fixed dollar amount, which you must pay for certain health services provided under this Benefit Plan. You are responsible for the payment of any Copayments directly to the provider when you receive health services.

G. **Cost-Sharing.** Amounts you must pay for covered services, expressed as Coinsurance, Copayments and/or Deductibles.

H. **Deductible.** A charge, expressed as a fixed dollar amount that you must pay once each Calendar Year before benefits will be provided for certain services covered under this Benefit Plan during that Calendar Year. (There are special Deductible rules when you have other than individual coverage. See Section Four.)

I. **Effective Date.** The date your coverage under this Benefit Plan 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.

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

K. **Emergency Services.** A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required "to stabilize" the patient.

L. **Facility**. A Hospital; ambulatory surgery facility; birthing center; dialysis center; rehabilitation facility; Skilled Nursing Facility; hospice; home health agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law (or the comparable law of the state where the services are provided); institutional provider of mental health care that is a hospital as defined by subdivision ten of section 1.03 of the New York Mental Hygiene Law (or the comparable law of the state where the services are provided); an institutional provider of chemical dependence and abuse treatment certified by the Office of Alcoholism and Substance Abuse Services ("OASAS") (or the comparable agency of the state where the services are provided); or other provider certified under Article 28 of the New York Public Health Law (or the comparable law of the state where the services are provided); or an independent clinical laboratory. If you receive treatment for chemical dependence or abuse outside of New York State, the Facility must have an operating certificate issued by a licensing authority comparable to OASAS and must also be accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), or a similar national organization, to provide the treatment.

M. **Formulary** means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Benefit Plan.

N. **Generic** drug means a Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Benefit Plan will consider as a Generic Drug any Food and Drug Administration approved Generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being Generic.

O. **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 is licensed pursuant to Article 28 of the Public Health Law of New York if located in New York State or the comparable law of the state where it is located. A Hospital is a licensed institution primarily engaged in providing:

(1) Inpatient diagnostic and therapeutic services for surgical and medical diagnosis;

(2) Treatment and care of injured and sick persons by or under the supervision of physicians; and

(3) Twenty-four (24) hour nursing service by or under the supervision of registered nurses.

None of the following are considered Hospitals:

(1) Places primarily for nursing care;

(2) Skilled Nursing Facilities;

(3) Convalescent homes or similar institutions;

(4) Institutions primarily for custodial care, rest, or as domiciles;

(5) Health resorts, spas, or sanitariums;

(6) Infirmaries at schools, colleges, or camps;

(7) Places primarily for the treatment of chemical dependency and abuse, hospice care, or rehabilitation; or

(8) Free standing ambulatory surgical centers.

P. **In-Network Benefits.** In-Network Benefits apply when your care is provided by Participating Providers. You may be responsible for meeting an annual Deductible and/or paying a Copayment or a Coinsurance amount on covered services.

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.** Lifetime means the maximum benefit payable during an individual's lifetime while covered under this Benefit Plan. This Benefit Plan may provide for a Lifetime maximum benefit for a specific type of covered service or treatment.

Any Lifetime maximum will be show in the section of this Benefit Plan in which the benefit is described.

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 of the Group, or an eligible dependent of an employee of the Group, who meets all applicable eligibility requirements and for whom the required premium payment has actually been received by the Group (or by Excellus BlueCross BlueShield on behalf of the Group, if applicable).

V. **Mental Health Disorder.** A mental, nervous or emotional condition that the Benefit Plan determines:

(1) Has treatable behavioral manifestations; and

(2) Meets the following requirements:

(a) Is a clinically significant alteration in thinking, mood or behavior, or a combination thereof; and

(b) Substantially or materially impairs your ability to function in one or more major life activities; and

(c) Has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

W. **Non-Participating Provider.** This Benefit Plan covers certain health care services described in this booklet when you receive the covered services from Non-Participating Providers. When you receive Out-of-Network Benefits, you will incur higher out-of-pocket expenses. In addition to any applicable Copayment or Coinsurance, you will be responsible for paying any difference between the Allowable Expense and the provider's charge.

X. **Out-of-Network Benefits.** The Out-of-Network Benefits portion of this Benefit Plan covers health care services described in this Booklet when you choose to receive the covered services from Non-Participating 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.

Y. **Out-of-Pocket Limit:** The most you pay during a Calendar Year in Deductibles, Copayments and Coinsurance before the Benefit Plan begins to pay 100% of the Allowable Expense for covered services. This limit never includes your premium,

balance billing charges or the cost of health care services the Benefit Plan does not cover.

Z. **Participating Provider:** A Facility, Professional Provider or Provider of Additional Health Services who has a contract with the Excellus BlueCross BlueShield or another Blue Cross and/or Blue Shield plan to provide health services to Members.

A list of Participating Providers and their locations is available at www.excellusbcbs.com. You may also obtain a paper copy, upon request and free of charge, by contacting the Excellus BlueCross BlueShield at the telephone number listed on your ID card.

AA. **Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

BB. **Prescription Drug** means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a sickness or injury.

CC. **Professional Provider.** A certified and licensed physician; osteopath; dentist; optometrist; chiropractor; registered psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; licensed midwife; speech-language pathologist; audiologist; or licensed pharmacist certified to administer immunizing agents. The 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 Benefit Plan.

DD. **Provider of Additional Health Services.** A provider of services or supplies covered under this Benefit Plan (such as diabetic equipment and supplies, prosthetic devices, or durable medical equipment) that is not a Facility or Professional Provider, and that is: licensed or certified according to applicable state law or regulation; approved by the applicable accreditation body, if any; and/or recognized by Excellus BlueCross BlueShield for payment under this Benefit Plan.

EE. **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.

FF. **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.

GG. **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.

HH. **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 Benefit Plan will provide coverage for your care in a Skilled Nursing Facility only if Excellus BlueCross BlueShield determines that the care is Skilled Care.

II. **"You", "Your", and "Yours"**. Throughout this Booklet, the words "you", "your" and "yours" refers to you, the employee or his/her dependents to whom this Booklet is issued. If other than individual coverage applies, then, in most

cases, the word “you” also includes any family members who are covered under this Benefit Plan.

SECTION TWO - WHO IS COVERED

1. **Who is Covered under this Benefit Plan.** Subject to the permissible eligibility rules of the Group, you, the employee of the Group to whom this booklet is issued, are covered under this Benefit Plan. If you selected other than individual coverage, the following members of your family may also be covered, subject to the permissible eligibility rules of the Group:

   A. Your spouse. If you are divorced or your marriage has been annulled, your former spouse is not covered. If you are divorced or your marriage has been annulled, your former spouse is ineligible as of the date the divorce decree is filed with the clerk. The County Employee Benefits Department must be notified within 31 days of divorce or annulment.

   B. Your children who are under the age of 26.

   C. Your child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attaining age 26 shall continue to be covered while your coverage under this Benefit Plan remains in effect and the child remains in such condition, if you submit proof of your child's incapacity within 31 days of your child attaining age 26. The Group and the Claims Administrator have the right to check whether a child continues to qualify under this provision.

      "Children" include: your natural children; a legally adopted child; a step child; a child for which you have been appointed legal guardian or granted legal custody by court order; and a child for whom 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. Any other child living in the household in which the employee contributes at least 50% support of the child and such child qualifies as a dependent of the employee for tax purposes and the employee is entitled to an exemption for such dependent on the most recent tax return filed by the employee. Foster children are not eligible for coverage under the Benefit Plan.

   No person may be eligible for benefits under this Benefit Plan as both an employee and a dependent or as a dependent of more than one (1) employee.

   The Group and the Claims Administrator have the right to request, and have furnished to them, such proof as may be needed to determine eligibility status of a prospective employee or member of the Group and all prospective dependents as they pertain to eligibility for coverage under this Benefit Plan.

2. **Types Of Coverage Other Than Individual Coverage.** The Benefit Plan offers family coverage in addition to employee only coverage. With family coverage you may elect coverage for you, your spouse and your eligible children; or you and your eligible children

The names of all persons covered under this Benefit Plan must have been specified on the enrollment form for this Benefit Plan. 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.

3. **When Coverage Begins**. Coverage under this Benefit Plan will begin as follows:

   A. If you, the employee, elect coverage within 31 days of becoming eligible, coverage begins at 12:01 a.m. after the applicable waiting period is satisfied;

   B. If you, the employee or member of the Group, do not elect coverage upon becoming eligible or within 31 days of becoming eligible, you must wait until the Group's open enrollment period, except as provided in Paragraph 4 below. Coverage then begins at 12:01 a.m. at the beginning of the Calendar Year after the next open enrollment period (the "Plan Year" is the twelve-month period from January 1st to December 31st each year); or

   C. If you, the employee or member of the Group, marry while covered, and Excellus BlueCross BlueShield receives notice of such marriage within 31 days thereafter, coverage for the spouse and any eligible dependents for whom you elect coverage starts at 12:01 a.m. on the first of the month after the marriage. Otherwise, application for spousal coverage must be submitted during the next open enrollment period, to become effective at 12:01am the beginning of the next calendar year.

4. **When You Reject Initial Enrollment, But Need to Enroll for Coverage Prior to the Group's Open Enrollment Period due to a Qualifying Event.** If you, the employee or member of the Group, reject initial enrollment under this Benefit Plan, you may enroll for coverage if the following conditions are met:

   A. You or your family member had coverage under another plan or contract when coverage was initially offered or at a subsequent open enrollment period; and

   B. Coverage was provided in accordance with continuation required by state or federal law and was exhausted; or coverage under the other plan or contract was terminated because you or your family member lost eligibility for one or more of the following reasons:

      (1) Termination of employment;

      (2) Termination of the other plan or contract;

      (3) Death of the spouse;

(4) Legal separation, divorce or annulment;

(5) Reduction in the number of hours worked;

(6) The employer or other group ceased its contribution toward the premium for the other plan or contract;

(7) The coverage was under an HMO, and you no longer live, work or reside in the HMO service area;

(8) Cessation of eligible child status;

(9) Benefits are no longer offered to similarly situated individuals (e.g., part-time employees); or

C. You acquire a family member due to birth, guardianship, adoption, placement for adoption, or marriage, in which case, you, the employee or member of the Group, may enroll for individual coverage or for a type of coverage available to your Group that will cover you and your eligible family members.

D. You or a family member lose eligibility for coverage under Medicaid, Family Health Plus, or Child Health Plus, or you become eligible for state premium assistance under Medicaid, Family Health Plus, or Child Health Plus.

E. You apply for coverage under this Benefit Plan within 31 days after termination for one of the reasons set forth in Subparagraph B above, or acquisition of a family member as set forth in Subparagraph C above; or you apply for coverage under this Benefit Plan within 60 days after the occurrence of an event set forth in Subparagraph D above.

If you enroll for coverage pursuant to Subparagraphs A and B, or Subparagraph D, your coverage will begin at 12:01 a.m. on the date of the loss of coverage or eligibility for state premium assistance. If you enroll for coverage pursuant to Subparagraph C above, your coverage will begin at 12:01 a.m. on: the date of the birth, adoption, guardianship or placement for adoption; or on the first day of the month following marriage, when you are entitled to a special enrollment period based on marriage.

5. **Notification of Change in Your Coverage**.

A. **To Add a Spouse or Child.** If you need to add a spouse or child to your coverage, you must complete and return to the Group an enrollment form for this purpose together with any requested documentation. The addition of a child will be effective as of the date of birth or adoption making the child eligible for coverage under Paragraph 1, if you return to your employer a completed enrollment form and requested documents within 31 days of the birth or adoption. The addition of a spouse or other dependent will be effective as of the date of the

marriage or other qualifying event making such individual eligible for coverage under this section or the date the election form is completed, whichever is later, if you return to your employer a completed enrollment form and requested documents within 31 days of the applicable event. If you do not return a completed election form and the requested documentation within 31 days, you will not be able to add the dependent until you reach the annual open enrollment period or experience another qualifying event. Any changes requested during the annual open enrollment, including the addition of a dependent, will be effective the following January 1.

B. **When Coverage of a Spouse or Child Terminates.** If you have other than Employee Only coverage, you must notify the Benefit Plan within 31 days of any event that affects your coverage, including, but not limited to, your divorce; separation; the death of your spouse; a Member becoming Medicare eligible, or a child marrying, reaching the age at which coverage terminates, or otherwise experiencing an event which would normally result in termination of dependent coverage. Failure to notify the Benefit Plan of changes in your family status which would cause dependent(s) to lose coverage could affect your right to COBRA continuation of benefits by the County under the COBRA law, as explained in the Termination of Coverage section of this document. In the case of a dependent that ceases to be eligible, you may be responsible for reimbursement of benefits paid after the date of the event that causes the dependent to lose eligibility.

6. **Open Enrollment Period**

This Benefit Plan has an annual open enrollment period. The open enrollment period is the period of time prior to the start of the Calendar Year where an eligible employee and/or eligible dependent can elect coverage under the Benefit Plan or can change coverage under the Benefit Plan. The open enrollment period under the Benefit Plan will be communicated to you each year by the Group.

If you fail to complete and submit the required election and enrollment forms within the annual open enrollment period, you will not be eligible to enroll in the Benefit Plan until the next annual open enrollment period, unless you experience an earlier special enrollment or a change in status event.

7. **Change in Status Event.**

Your election under the Benefit Plan will remain in effect for the entire Calendar Year, unless you experience a special enrollment event (described below) or a change in status event, as defined under Section 125 of the Internal Revenue Code (including any applicable regulations). Any new election made under the Benefit Plan due to a change in status event must be consistent with such event. Change in status events include:

(a) A change in your marital status, including marriage, divorce, legal separation, annulment or death of a spouse;

(b) A dependent loses or gains eligibility under the Benefit Plan, such as

attainment of a specified age; birth, adoption or placement for adoption of a dependent; death of a dependent; or a change in the Benefit Plan's dependent eligibility requirements;

(c) Change in employment status that causes you, your spouse or dependent child to either gain or lose eligibility under the Benefit Plan, including commencement or termination of employment; commencement or return from a leave of absence; or any other employment status change that affects the eligibility status of an individual to participate in the Benefit Plan, including a change from part-time to full-time status or vice versa, a change from salaried to hourly or vice versa, or a strike or lockout;

(d) Gain or loss of eligibility under the Benefit Plan or another employer-sponsored welfare benefit plan;

(e) Significant increase or decrease in the cost of coverage under the Benefit Plan, including a new benefit option being added, a benefit option being eliminated or significantly curtailed and a coverage change made under a plan offered by the Group;

(f) Change in your residence or the residence of your dependent that is outside the Benefit Plan's Service Area;

(g) Change in election under another employer-sponsored welfare benefit plan during an open enrollment period under another employer-sponsored welfare benefit plan that differs from the open enrollment period under this Benefit Plan;

(h) You or your dependent become covered or lose coverage under Medicare or Medicaid.

Depending on the change in status event, you may be permitted to revoke your existing election or make a new election under the Benefit Plan, provided it is consistent with the event and satisfies the regulations under Internal Revenue Code Section 125. For additional information regarding whether or not something constitutes a change in status event, please contact the Group.

Coverage under the Benefit Plan will begin as of the date of the change in status event, provided you request enrollment and submit any required election and enrollment forms no later than 31 days after the event.

Failure to enroll in the Benefit Plan within the 31-day period described above will result in no coverage under the Benefit Plan. You may elect to enroll in the Benefit Plan again during the Benefit Plan's next annual open enrollment period, or in the event you experience another special enrollment or change in status event.

SECTION THREE - MEDICAL NECESSITY AND PRIOR APPROVAL

1. **Care Must Be Medically Necessary.** The Benefit Plan 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 Benefit Plan 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.** If services are rendered by a Participating Provider, your provider is required to obtain prior approval for certain services covered under this Program. If services are rendered by a Non-Participating Provider, you are required to obtain prior approval for certain services covered under this Program. A list of services that require prior approval is attached to this Booklet as Exhibit A. This list is subject to change and is updated from time to time. To verify whether or not a specific service requires prior approval, please contact the customer service number listed on your ID card.

4. **Prior Approval Procedure.** If you seek coverage for the services listed in Paragraph 3 above, you must call the number indicated on your 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 within 24 hours after your admission or as soon thereafter as reasonably possible. However, you must call as soon as it is reasonably possible in order for any follow-up care to be covered without the reduction described in Paragraph 5 below. 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, the Claims Administrator will review the reasons for your planned treatment and determine if benefits are available. The Claims Administrator will notify you and your Professional Provider of the 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, the Claims Administrator will

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

5. **Failure To Seek Approval.** If your Participating Provider fails to seek prior approval for benefits subject to this section, other than with respect to any benefits received due to an Emergency Condition, the Program will not provide any coverage for those services; however, you, the member, will be held harmless and not subject to any penalties. If you fail to seek prior approval for services rendered by a Non-Participating Provider, no penalty will apply. The Benefit Plan will pay the amount specified above only if it is determined that the care was Medically Necessary. If it is determined that services were not Medically Necessary, you will be responsible for paying the entire charge for the service.

6. **Your Right To Appeal.** If you or your Professional Provider disagrees with our decision, you may appeal by following the procedures set forth in Section Nineteen, paragraph 25. Any written appeals must be made to the Claims Administrator at: 165 Court Street, Rochester, NY 14647.

SECTION FOUR - COST SHARING EXPENSES

1. **Coinsurance.** Except where stated otherwise, after you have satisfied the annual Deductible amount described below, you will be responsible for a percentage of the Allowable Expense, which is your Coinsurance. The Coinsurance amounts are as follows:

   A. Your Coinsurance for In-Network Benefits is 0%.

   B. Your Coinsurance for Out-of-Network Benefits is 25%.

2. **Copayments.** The Copayments you must pay for covered services when you are entitled to certain benefits as provided under the terms of the Benefit Plan are set forth in the Section of this booklet where the particular service is described. Unless otherwise stated, a Copayment is due directly to the Provider each time you receive the applicable health services.

3. **Deductible.** The Deductible is a fixed dollar amount which you must pay each Calendar Year before the Benefit Plan will pay anything for covered medical services during that Calendar Year. The Deductibles are as follows:

   A. If you have individual coverage you must pay the first $500 of Allowable Expenses for Out-of-Network Benefits, excluding Copayments, incurred under the Benefit Plan during each Calendar Year.

   B. If you have family coverage, the Deductible applies to each person covered under the Benefit Plan. However, after Deductible payments for any and all persons covered under the Benefit Plan total $1,500 for Out-of-Network Benefits in a Calendar Year, no further Deductible will be required for an person covered under the Benefit Plan for the applicable Calendar Year.

   If the Deductible is satisfied in whole or in part by eligible expenses incurred during October, November or December of any given year, those eligible expenses will count towards and apply to the Deductible applicable in the next Calendar Year.

4. **Out-of-Pocket Limit.** When you have expended a certain amount in-network and out-of-network Coinsurance, Copayments and Deductibles in a Calendar Year, the Plan will provide coverage for 100% of the Allowable Expense for In-Network Benefits and Out-of-Network Benefits covered under the Plan for the remainder of the applicable Calendar Year.

Medical Coverage under the Benefit Plan

A. If you have individual coverage, the total Out-of-Pocket Limit for In-Network Benefits or Out-of-Network Benefits for durable medical equipment only is $500. The Out-of-Pocket Limit for all other In-Network Benefits is $1,500. The Out-of-Pocket Limit is $2,000 for all other Out-of-Network Benefits.

B. If you have family coverage, the total Out-of-Pocket Limit for In-Network Benefits or Out-of-Network Benefits for durable medical equipment only is $1,500. The Out-of-Pocket Limit for all other In-Network Benefits is $4,500. The Out-of-Pocket Limit for all other Out-of-Network Benefits is $6,000.

If you have other than individual coverage, once a person within a family has paid $1,500 (in-network) or $2,000 (out-of-network) Coinsurance, Copayments and Deductibles (other than for durable medical equipment) the Benefit Plan will provide coverage for 100% of the Allowable Expense for the rest of that Calendar Year for that person. If you have other than individual coverage, once a person within a family has paid $500 in in-network or out-of-network Coinsurance, Copayments and Deductible for durable medical equipment, the Benefit Plan will provide coverage for 100% of the Allowable Expense for any other durable medical equipment for the rest of that Calendar Year for that person.

The in-network and out-of-network Out-of-Pocket Limits accumulate separately. This means that any in-network Coinsurance, Copayment or Deductible paid by you count towards the in-network Out-of-Pocket Limit and do not count towards the out-of-network Out-of-Pocket Limit. Any out-of-network Coinsurance, Copayment or Deductible paid by you count towards the out-of-network Out-of-Pocket Limit and does not count towards the in-network Out-of-Pocket Limit.

Payment for any charges for a service provided by a Non-Participating Provider that exceeds the Allowable Expense will be your responsibility.

Prescription Drug Coverage under the Benefit Plan

A. If you have individual coverage, the total Out-of-Pocket Limit for In-Network Benefits is $5,350.

B. If you have family coverage, the total Out-of-Pocket Limit for In-Network Benefits is $9,200.

If you have other than individual coverage, once a person within a family has paid $5,350 for In-Network Copayments or Coinsurance the Benefit Plan will provide coverage for 100% of the Allowable Expense for the rest of that Calendar Year for that person.

Out-of-Network Benefits for Prescription Drugs are not covered.

5. **Additional Payments for Out-of-Network Benefits.** When you receive covered services from an Out-of-Network Provider, in addition to any cost-sharing that may apply, you must also pay the amount, if any, by which the provider's actual charge exceeds the Allowable Expense. This means that the total of the Benefit Plan's coverage and the cost-sharing amount you are responsible for may be less than the provider's actual charge.

When you receive covered services from an Out-of-Network Provider, the Benefit Plan will apply nationally recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services you received. Sometimes, applying these rules will change the way that the Benefit Plan pays for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. As an example, your provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. The Benefit Plan will make one inclusive payment in that case, rather than a separate payment for each billed code. Another example of when the Benefit Plan will apply the payment rules to a claim is when you have surgery that involves two surgeons acting as "co-surgeons". Under the payment rules, the claim from each provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If the Benefit Plan receives a claim that does not have the correct modifier, the Benefit Plan will change it and make the appropriate payment.

When you receive services from an Out-of-Network Provider, you must always pay the difference between the Allowable Expense and the provider's charge.

SECTION FIVE - INPATIENT CARE

1. **In a Facility.** If you are a registered bed patient in a Facility, the Benefit Plan 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 Benefit Plan 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 Benefit Plan'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 Benefit Plan will provide coverage for blood required for the treatment of hemophilia. However, the Benefit Plan 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 Benefit Plan will provide coverage when you are required to stay in a Hospital for Acute medical, surgical or mental health care and substance use disorder.

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

      (1) A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;

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

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

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

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

The Benefit Plan also covers inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities that provide services defined in 14 NYCRR 819.2(a)(1) and Part 817; 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 Benefit Plan will provide coverage for care in a Skilled Nursing Facility if Excellus BlueCross BlueShield determines that hospitalization would otherwise be Medically Necessary for the care of your condition, illness, or injury for up to 100 days in a Calendar Year. Admission to a Skilled Nursing Facility must be within seven (7) days of a prior Hospital stay. In-Network Benefits and Out-of-Network Benefits for a Skilled Nursing Facility will both be counted toward the 100 day Calendar Year limit described above.

E. **Physical Medicine and Rehabilitation.** The Benefit Plan will provide coverage for comprehensive physical medicine and rehabilitation (chemical dependence and abuse programs are excluded) up to 60 days per Calendar Year for a condition that in the judgment of your In-Network Provider and the Medical Director can reasonably be expected to result in significant improvement within a relatively short period of time. In-Network Benefits and Out-of-Network Benefits will both be counted toward the 60 day Calendar Year limit described above.

4. **Maternity Care.** The Benefit Plan 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 Benefit Plan, 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 Benefit Plan 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 Benefit Plan will provide coverage of the home care visit furnished by the type of home care agency described in Section Seven of this Booklet. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. The Benefit Plan's coverage of this home care visit shall not be subject to any Coinsurance or Copayments.

5. **Mastectomy Care.** The Benefit Plan'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 Benefit Plan will also provide coverage for prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

6. **Internal Prosthetic Devices.** The Benefit Plan 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.

7. **Observation Stay.** The Benefit Plan will provide coverage for observation services for up to 48 hours. Observation services are: furnished in the outpatient department of a Facility; and are in lieu of an inpatient admission. The services include: use of a bed; and periodic monitoring by nursing or other licensed staff that is reasonable and necessary to evaluate the patient's condition or determine the need for an inpatient admission.

8. **Payments for Inpatient Care**.

In-Network. In-Network Benefits other than for routine newborn nursery care and implanted prosthetic devices are subject to a $75 Copayment. In-Network Benefits for routine newborn nursery care and implanted prosthetic devices are covered at 100% of the Allowable Expense.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

SECTION SIX - OUTPATIENT CARE

The Benefit Plan 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 Benefit Plan will only provide coverage if Excellus BlueCross BlueShield determines that it was necessary to use the Facility to perform the surgery.

   In-Network. In-Network Benefits are subject to a $75 Copayment.

   Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

2. **Pre-Admission Testing.** The Benefit Plan will provide coverage for tests ordered by a Professional Provider 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.

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

   Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

3. **Diagnostic Procedures.** The Benefit Plan will provide coverage for diagnostic procedures, including x-rays and imaging.

   In-Network. In-Network Benefits are subject to a $25 Copayment.

   Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

4. **Diagnostic and Routine Laboratory and Pathology.** The Benefit Plan will provide coverage for diagnostic and routine laboratory and pathology.

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

5. **Radiation Therapy and Chemotherapy.** The Benefit Plan will provide coverage for radiation therapy and chemotherapy.

In-Network. In-Network Benefits are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

6. **Routine X-Rays.** The Benefit Plan will provide coverage for routine x-rays.

In-Network. In-Network Benefits are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

7. **Hemodialysis.** The Benefit Plan will provide coverage for hemodialysis treatments of an Acute or chronic kidney ailment.

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

Out-of-Network. Out-of-Network Benefits covered at 75% of the Allowable Expense, after Deductible.

8. **Injectable Drugs.** The Benefit Plan will provide coverage for drugs that are administered by injection during the course of an outpatient visit covered under this section, including chemotherapy injections and oral chemotherapy. Vaccines, allergy injections and treatment of diabetes are not covered under this section of the Benefit Plan. Such items are covered under other sections under this Benefit Plan.

In-Network. In-Network Benefits for Members under the age of 19 are subject to a $20 Copayment. In-Network Benefits for Members age 19 and older are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits covered at 75% of the Allowable Expense, after Deductible.

9. **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.** The Benefit Plan covers mammograms for the screening of breast cancer as follows:

- 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 Benefit Plan covers mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Calendar 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 Benefit Plan also covers additional screening and diagnostic imaging, including breast ultrasounds and MRIs, for the detection of breast cancer.

In-Network Benefits and Out-of-Network Benefits will both be counted towards the one (1) screening limitation described above.

In-Network. In-Network Benefits for preventive mammograms are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic mammograms are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

10. **Cervical Cytology Screenings (Pap Smears).** The Benefit Plan will provide coverage, subject to the limitations described below, for one screening 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 Benefit Plan's coverage under this Section and Section Nine is subject to the one-visit limit above. Cervical cytology screening shall mean a pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

In-Network Benefits and Out-of-Network Benefits will both be counted towards the one (1) screening limitation described above.

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

11. **Colonoscopy.** The Benefit Plan will provide coverage for colonoscopies to screen for colon cancer in asymptomatic Members age 50 and older. Diagnostic colonoscopies will also be covered.

In-Network. In-Network Benefits for preventive services are covered at 100% of the Allowable Expense. In-Network benefits for diagnostic services are subject to a $75 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

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

The Benefit Plan does not cover:

A. Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;

B. Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by a governmental agency; or

C. Services solely because they are ordered by a court.

In-Network. In-Network Benefits for services other than psychological testing are subject to a $20 Copayment. In-Network Benefits for psychological testing are covered at 100% of the Allowable Expense.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

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

and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

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

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

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

14. **Covered Therapies.** The Benefit Plan will provide coverage for related rehabilitative and habilitative physical therapy, occupational therapy, 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.

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

Out-of-Network. Out-of-Network Benefits are covered at 50% of the Allowable Expense, after Deductible.

15. **Pulmonary Rehabilitation.** The Benefit Plan 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. Pulmonary rehabilitation is limited to 36 visits per Calendar Year. This visit limit is combined with any professional services rendered under Section Nine of this Booklet. In-Network Benefits and Out-of-Network Benefits will both be counted towards the 36-visit limit described above.

In-Network. In-Network Benefits are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible

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

Cardiac rehabilitation is limited to 54 visits per Calendar Year. This visit limit is combined with any professional services rendered under Section Nine of this Booklet. In-Network Benefits and Out-of-Network Benefits will both be counted towards the 54-visit limit described above.

In-Network. In-Network Benefits are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

SECTION SEVEN - HOME CARE

1. **Type of Home Care Provider.** The Benefit Plan will provide coverage for home care visits given by a certified home health agency in New York or a licensed home care services agency in New York 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 Benefit Plan 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 Benefit Plan 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 Benefit Plan will provide coverage for up to 40 home care visits in a Calendar Year, beginning with the first day on which care is provided.

   In-Network Benefits and Out-of-Network Benefits will both be counted toward this 40-visit maximum listed above.

6. **Payments for Home Care**.

   In-Network. In-Network Benefits for services other than home IV therapy are subject to a $75 Copayment. There is a maximum of one (1) Copayment every Calendar Year. In-Network Benefits for home IV therapy are subject to a $25 Copayment per visit.

   Out-of-Network. Out-of-Network Benefits are covered at 75% 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 Benefit Plan 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 Benefit Plan 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 Benefit Plan 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 Benefit Plan will provide coverage for up to 210 inpatient days and outpatient care visits per Lifetime. The Benefit Plan will also provide coverage for up to five (5) visits per Calendar Year for bereavement counseling services to your family, either before or after your death. In-Network Benefits and Out-of-Network Benefits will both be counted towards the 210-day and five (5) visit limitation described above.

5. **Payments for Hospice Care**.

In-Network. In-Network Benefits are subject to a $75 Copayment. There is a maximum of one (1) Copayment every 12 months.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

SECTION NINE - PROFESSIONAL SERVICES

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

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

   The Benefit Plan will also provide coverage for surgical services including all stages of reconstructive surgery on a breast on which a mastectomy has been performed. The Benefit Plan 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 Benefit Plan will provide coverage for surgical procedures performed while you are an inpatient in a Hospital or other Facility.

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

      Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

   B. **Outpatient Surgery.** The Benefit Plan 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.

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

      Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

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

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

      Out-of-Network. Out-of-Network Benefits covered at 75% of the Allowable Expense, after Deductible.

2. **Covered Therapies.** The Benefit Plan will provide coverage for related rehabilitative and habilitative physical therapy, occupational therapy, 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.

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

Out-of-Network. Out-of-Network Benefits for services other than rehabilitative and habilitative physical therapy are covered at 50% of the Allowable Expense, after Deductible. Out-of-Network Benefits for rehabilitative and habilitative physical therapy are covered at 75% 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, either inpatient, outpatient or during an office visit. The administration and related procedures must be done by a Professional Provider other than the Professional Provider performing the surgery or an assistant. The Benefit Plan will not provide coverage for the administration of anesthesia for a procedure not covered by the Benefit Plan.

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

   Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

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

   A. The Benefit Plan 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 Benefit Plan 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 Benefit Plan 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.

In-Network. In-Network Benefits for Members under the age of 19 are subject to a $20 Copayment. In-Network Benefits for Members age 19 or older are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

5. **Second Medical Opinions.** The Benefit Plan 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 Benefit Plan 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.

In-Network. In-Network Benefits for Members age under the age of 19 are subject to a $20 Copayment. In-Network Benefits for Members age 19 or older are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

6. **Maternity Care.** The Benefit Plan 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 (or comparable law of the state where services are provided). Any laboratory testing or diagnostic imaging is not covered under this Paragraph. These items are subject to the applicable coverage and cost sharing under the appropriate provisions (such as Section Nine, Paragraph 8(B)(1) and Section Nine, Paragraph 9).

In-Network. In-Network Benefits for the initial visit are subject to a $25 Copayment, all subsequent visits are covered at 100% of the Allowable Expense.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

B. **Hospital Care for Mother.** The Benefit Plan will provide coverage for hospital care of the mother, including delivery.

In-Network. In-Network Benefits are subject to a $75 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

C. **Complications of Pregnancy and Termination.** The Benefit Plan will provide coverage for complications of pregnancy and for termination of pregnancy, when Medically Necessary due to the life of the mother being in danger.

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

D. **Anesthesia.** The Benefit Plan will provide coverage for delivery anesthesia.

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

E. **Newborn Nursery Coverage.** The Benefit Plan will provide coverage for newborn nursery care.

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

7. **In-Hospital Medical Services.** The Benefit Plan will provide coverage for medical visits by a Professional Provider on any day of hospitalization covered under Section Five. The Benefit Plan 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 Benefit Plan 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.

In-Network. In-Network Benefits for inpatient medical visits are covered at 100% of the Allowable Expense. In-Network Benefits for inpatient consultations are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% 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 Benefit Plan 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 Benefit Plan will provide coverage for up to one periodic adult routine physical examination per year in accordance with the United States Task Force on Preventative Care.

In-Network Benefits and Out-of-Network Benefits will both be counted toward the one-visit limit described above.

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

(2) **Well Child Visits and Immunizations**. The Benefit Plan will provide coverage for In-Network well child visits in accordance with the schedule recommended by the United States Task Force on Preventative Care. Specifically, well child visits will be covered at ages: five days; three weeks; and 2, 4, 6, 9, 12, 15, 18, 24, and 30 months. In addition, well child visits will be covered once every Calendar Year for ages 3 through 18. The Benefit Plan will also cover childhood immunizations recommended by the American Academy of Pediatrics, in accordance with the Academy's recommended schedule.

The Benefit Plan 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.

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

(3) **Adult Immunizations.** The Benefit Plan will provide coverage for adult immunizations when Medically Necessary in accordance with prevailing medical standards.

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

B. **Other Health Services**.

(1) **Laboratory and Pathology Services.** The Benefit Plan will provide coverage for diagnostic and routine laboratory and pathology services.

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

(2) **X-Rays.** The Benefit Plan will provide coverage for diagnostic and routine x-rays.

In-Network. In-Network Benefits are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

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

Routine eye examinations are limited to one (1) exam every twelve months based on the date of service. Refraction applies to this limitation.

In-Network Benefits and Out-of-Network Benefits will both be counted towards the one (1) exam limit described above.

In-Network. In-Network Benefits are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

(4) **Hearing Examinations.** The Benefit Plan will provide coverage for diagnostic and routine hearing examinations.

In-Network. In-Network Benefits are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

C. **Diagnostic Office Visits.** The Benefit Plan will provide coverage for diagnostic office visits.

In-Network. In-Network Benefits for Members under the age of 19 are subject to a $20 Copayment. In-Network Benefits for Members age 19 or older are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

D. **Office Consultations.** The Benefit Plan 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.

In-Network. In-Network Benefits for Members under the age of 19 are subject to a $20 Copayment. In-Network Benefits for Members age 19 or older are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

E. **Injectable Drugs.** The Benefit Plan will provide coverage for drugs that are administered by injection during the course of an outpatient visit covered under this section, including chemotherapy injections and oral chemotherapy. Vaccines, allergy injections, treatment of diabetes are not covered under this section of the Benefit Plan. Such items are covered under other sections under this Benefit Plan.

In-Network. In-Network Benefits for Members under the age of 19 are subject to a $20 Copayment. In-Network Benefits for Members age 19 or older are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits covered at 75% of the Allowable Expense, after Deductible.

F. **Infusion Therapy.** The Benefit Plan will provide coverage for infusion therapy.

In-Network. In-Network Benefits are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

9. **Diagnostic Imaging Examinations and Diagnostic Radioactive Isotope Procedures.** Subject to the provisions below, the Benefit Plan 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 Benefit Plan 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 Benefit Plan will provide the CAT scan or other procedure only if the New York State Public Health Law (or the comparable law of the state where the service is provided) 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.

   In-Network. In-Network Benefits are subject to a $25 Copayment.

   Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

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

    In-Network. In-Network Benefits are subject to a $25 Copayment.

    Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

11. **Hemodialysis.** The Benefit Plan will provide coverage for hemodialysis treatments of an Acute or chronic kidney ailment.

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

    Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

12. **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.** The Benefit Plan covers mammograms for the screening of breast cancer as follows:

- 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 Benefit Plan covers mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Calendar 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 Benefit Plan also covers additional screening and diagnostic imaging, including breast ultrasounds and MRIs, for the detection of breast cancer.

In-Network Benefits and Out-of-Network Benefits will both be counted towards the one (1) screening limitation described above.

In-Network. In-Network Benefits for preventive mammograms are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic mammograms are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

13. **Gynecological Services.** The Benefit Plan will provide coverage, subject to the limitations stated below, for gynecology visits, including coverage for one screening for cervical cancer and its precursor states each Calendar Year for women 18 years of age and older. The screenings may be provided in the outpatient department of a Facility pursuant to Section Six, Paragraph 7 or in a Professional Provider's office pursuant to this Section. Coverage under this Section and Section Six, Paragraph 7, is subject to the one-visit limit above. 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.

In-Network Benefits and Out-of-Network Benefits both count toward the one-visit limit described above.

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

14. **Screenings for Prostate Cancer**. The Benefit Plan will provide coverage for In-Network routine testing for prostate cancer when prescribed by a health care practitioner legally authorized to prescribe under Title 8 of the New York Education Law (or the comparable law of the state where the service is provided). The Benefit Plan 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.

    In-Network Benefits and Out-of-Network Benefits will both be counted toward the one exam limit described above.

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

    Out-of-Network. Out-of-Network Benefits are covered at 25% of the Allowable Expense, after Deductible.

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

    In-Network. In-Network Benefits for allergy testing for Members under the age of 19 are subject to a $20 Copayment. In-Network Benefits for allergy testing for Members age 19 or older are subject to a $25 Copayment. In-Network Benefits for allergy treatment are covered at 100% of the Allowable Expense.

    Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

16. **Colonoscopy.** The Benefit Plan will provide coverage for colonoscopies to screen for colon cancer in asymptomatic Members. Diagnostic colonoscopies will also be covered.

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

    Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

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

three years of additional experience in psychotherapy; or a professional corporation or a university faculty practice corporation thereof.

The Benefit Plan does not cover:

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

C. Services solely because they are ordered by a court.

In-Network. In-Network Benefits for services other than psychological testing are subject to a $20 Copayment. In-Network Benefits for psychological testing are covered at 100% of the Allowable Expense.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

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

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

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

19. **Chiropractic Care.** The Benefit Plan will provide coverage for up to 30 visits per Calendar Year 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.

    In-Network Benefits and Out-of-Network Benefits will both be counted towards the 30-visit maximum described above.

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

    Out-of-Network. Out-of-Network Benefits are covered at 50% of the Allowable Expense, after Deductible.

20. **Inpatient Consultations.** The Benefit Plan 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.

    In-Network. In-Network Benefits are subject to a $25 Copayment.

    Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

21. **Pulmonary Rehabilitation.** The Benefit Plan 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. Pulmonary rehabilitation is limited to 36 visits per Calendar Year. This visit limit is combined with any outpatient services rendered under Section Six of this Booklet. In-Network Benefits and Out-of-Network Benefits will both be counted towards the 36-visit limit described above.

In-Network. In-Network Benefits are subject to a $25 Copayment.

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

22. **Cardiac Rehabilitation.** The Benefit Plan will provide coverage for Medically Necessary Phase I and Phase II cardiac rehabilitation programs. Services must be rendered by an approved cardiac rehabilitation program provider and recommended by the Member's cardiologist or Professional Provider. Cardiac rehabilitation is limited to 54 visits per Calendar Year. This visit limit is combined with any outpatient services rendered under Section Six of this Booklet. In-Network Benefits and Out-of-Network Benefits will both be counted towards the 54-visit limit described above.

In-Network. In-Network Benefits are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

23. **Infertility Services**. The Benefit Plan will provide coverage for Medically Necessary services for the diagnosis of infertility subject to the following conditions:

A. **Infertility Defined.** For the purposes of this Paragraph, infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse.

B. **Coverage Only Provided for Appropriate Candidates.** Coverage under this Paragraph will only be provided to "Appropriate Candidates." An Appropriate Candidate is an individual determined to be an Appropriate Candidate by the treating physician, in accordance with the standards and guidelines established and adopted by the New York State Insurance Department by regulation.

C. **Covered Services.** Subject to the other provisions of this Paragraph and the Benefit Plan, benefits will be provided under this Paragraph for services in relation to diagnostic tests and procedures necessary to determine infertility

D. **Deductible, Copayments and Coinsurance.** The benefits of this Paragraph are subject to any applicable Deductible, Copayments or Coinsurance provisions under this Section Nine for similar services. For example, any Deductible, Copayment or Coinsurance for Surgical Care under Paragraph 1 will also apply to surgical services under this Paragraph; any Deductible, Copayment or Coinsurance for Laboratory and Pathology Services under Paragraph 8 (B)(1) will

also apply to laboratory and pathology services under this Paragraph; and any Deductible, Copayment or Coinsurance for x-ray and imaging procedures under Paragraph 9 will also apply to x-ray and imaging procedures under this Paragraph.

24. **Elective Sterilization**. The Benefit Plan 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 Benefit Plan will provide coverage for Medically Necessary inpatient care in connection with elective sterilization in accordance with the inpatient care benefit described in Section Five.

    B. The Benefit Plan will provide coverage for Medically Necessary outpatient care in connection with elective sterilization in accordance with the outpatient care benefit described in Section Six.

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

    Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

25. **Bone Density Testing.** The Benefit Plan will cover bone mineral density measurements and tests for the detection of osteoporosis. The Benefit Plan 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, including women over age 65 and women over age 60 who are at increased risk for osteoporotic fractures.

    In-Network. In-Network Benefits other than those that are considered preventive services in accordance with Section Ten are subject to a $25 Copayment. In-

Network Benefits for preventive services are covered at 100% of the Allowable Expense.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

SECTION TEN - ADDITIONAL BENEFITS

1. **Treatment of Diabetes.** The Benefit Plan will provide coverage for the following equipment and supplies for the treatment of diabetes that the Claims Administrator determines 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"):

   A. Blood glucose monitors;

   B. Blood glucose monitors for the visually impaired;

   C. Data management systems;

   D. Injection aids;

   E. Cartridges for the visually impaired;

   F. Insulin pumps and appurtenances thereto;

   G. Insulin infusion devices; and

   H. Additional Medically Necessary equipment and supplies, as determined by the Claims Administrator as appropriate for the treatment of diabetes in accordance with its administrative guidelines.

   Repair, replacement and adjustment of the above diabetic equipment 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 Benefit Plan will also pay for disposable syringes and needles used solely for the injection of insulin. The Benefit Plan will not pay for reusable syringes and needles or multi-use disposable syringes or needles.

   The Benefit Plan will pay for diabetes self-management education and diet information provided by your Professional Provider or 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 the Claims Administrator. 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 Benefit Plan will also pay for home visits, when Medically Necessary.

Education is also covered when provided by the following medical personnel upon a referral from your Professional Provider or Authorized Medical Personnel: certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician or other provider as required by law. Such education must be provided in a group setting, when practicable.

The Group provides prescription drug coverage under a separate plan or policy. Any services or supplies for the treatment of diabetes covered under the prescription drug plan or policy will not be covered under the Benefit Plan.

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

2. **Durable Medical Equipment**. The Benefit Plan will provide coverage for the rental, purchase, repair, or maintenance of durable medical equipment (including BiPAP/CPAP machines and supplies). The Benefit Plan 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. Please contact Excellus BlueCross BlueShield for a copy of Policy Number 1.01.00, Durable Medical Equipment – Standard and Non-Standard, for more information on coverage of durable medical equipment. 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 Benefit Plan will not provide coverage for delivery or service charges, or for routine maintenance.

In-Network. In-Network Benefits are covered at 75% of the Allowable Expense.

Out-of-Network. Out-of-Network Benefits for durable medical equipment other than oxygen are covered at 50% of the Allowable Expense, after Deductible. Out-of-Network Benefits for oxygen are covered at 25% 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.

3. **External Prosthetic Devices**. The Benefit Plan 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 Benefit Plan 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 Benefit Plan 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. 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 Benefit Plan 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 Benefit Plan will not provide coverage for delivery or service charges, or for routine maintenance related to prosthetic devices. Please contact Excellus BlueCross BlueShield for a copy of Policy Number 1.01.08, Prosthetic Devices, for more information on coverage of Prosthetics.

   Hair prosthetics (i.e. wigs) are covered only when there is a diagnosis of cancer. Hair prosthetics are covered up to a maximum of (1) per Lifetime and a maximum of $400 per Lifetime. In-Network Benefits and Out-of-Network Benefits will both be counted towards the Lifetime maximum described above.

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

   Out-of-Network. Out-of-Network Benefits other than for wigs are covered at 75% of the Allowable Expense, after Deductible. Out-of-Network Benefits for wigs are covered at 100% of the Allowable Expense.

   You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

4. **Orthotic Devices.** The Benefit Plan 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, including foot orthotics. Shoe inserts, orthopedic and diabetic shoes are not covered. Your physician must order the orthotic device for your condition before its purchase. Although the Benefit Plan 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 Benefit Plan will only provide benefits for an orthotic device that can adequately meet the needs of your condition at the least cost. Please contact Excellus BlueCross BlueShield for a copy of Policy Number 1.01.25, Orthotics, for more information on coverage of Orthotics.

In-Network. In-Network Benefits are covered at 75% of the Allowable Expense.

Out-of-Network. Out-of-Network Benefits are covered at 50% 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. **Medical Supplies.** The Benefit Plan 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 including 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. 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.

   Compression stockings are limited to two (2) per Calendar Year. In-Network Benefits and Out-of-Network Benefits will both be counted towards the two (2) per Calendar Year limit described above.

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

   Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

6. **Breast Pump.** The Benefit Plan will provide coverage for up to one (1) rental or purchase per live pregnancy, regardless of Medically Necessity. In-Network Benefits and Out-of-Network Benefits are both counted toward the one (1) limit described above.

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

   Out-of-Network. Out-of-Network Benefits are covered at 50% of the Allowable Expense, after Deductible.

7. **Ambulance Service**. The Benefit Plan 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 Benefit Plan 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 Benefit Plan will provide coverage 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 Benefit Plan 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 New York Public Health Law (or the comparable law of the state where the service is provided). The Benefit Plan 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.

In-Network. In-Network Benefits are subject to a $75 Copayment.

Out-of-Network. Out-of-Network Benefits are subject to a $75 Copayment.

Individual Case Management.

8. **Alternative Benefits.** If you agree to participate and abide by Excellus BlueCross BlueShield's policies, in addition to benefits specified in this Booklet, the Benefit Plan 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 Benefit Plan 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 Benefit Plan in the absence of alternative benefits.

If the Benefit Plan elects to provide alternative benefits for a Member in one instance, it shall not obligate the Benefit Plan 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 Benefit Plan 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 Benefit Plan 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 Benefit Plan would normally provide to you under the Benefit Plan ("the Benefit Plan benefits") for the treatment of your condition. As a result, we may require you to agree to waive certain Benefit Plan benefits in order to receive the alternative benefits agreed upon. You may return to utilization of Benefit Plan benefits at any time upon prior written notice to Excellus BlueCross BlueShield. However, the Benefit Plan benefits remaining available to you will be reduced in a manner that appropriately reflects the alternative benefits you used, except to the extent any law prohibits the reduction of benefits.

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 the decision.

9. **PUVA Therapy.** The Benefit Plan will provide coverage for PUVA therapy.

   In-Network. In-Network Benefits are subject to a $25 Copayment.

   Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

10. **Blood Products.** The Benefit Plan will provide coverage for blood charges (when not available free of charge), even if you donate or store your own blood, if billed by a Facility, ambulatory surgery center, or a certified blood bank.

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

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

11. **Shock Therapy.** The Benefit Plan will provide coverage for outpatient shock therapy when Medically Necessary.

    In-Network. In-Network Benefits are subject to a $25 Copayment.

    Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

12. **Smoking Cessation Counseling.** The Benefit Plan will provide coverage for up to eight (8) smoking cessation counseling sessions per Calendar Year.

    In-Network Benefits and Out-of-Network Benefits will both be counted towards the 8 session limit described above.

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

    Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

13. **Nutritional Counseling.** The Benefit Plan will provide coverage for nutritional counseling in accordance with the requirements of the preventive services provision below. Nutritional counseling visits are limited to 26 visits per Calendar Year.

    In-Network Benefits and Out-of-Network Benefits will both be counted towards the 26-visit limit described above.

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

    Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

14. **Accidental Dental.** The Benefit Plan will provide coverage for Medically Necessary treatment for a fractured jaw and/or accidental injury to sound natural teeth provided within twelve (12) months of an accidental injury. The Benefit Plan does not consider an injury to a tooth caused by chewing or biting to be an accidental injury.

    In-Network. In-Network Benefits are subject to a $25 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

15. **Nutritional Therapy.** The Benefit Plan will provide coverage for Medically Necessary nutritional therapy, total parenteral nutrition, enteral formula and hyperalimentation.

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

    Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

16. **Medical and Diabetic Foot Care.** The Benefit Plan will provide coverage for diabetes mellitus, peripheral vascular disease, peripheral neuropathy, sever collage vascular diseases (e.g. rheumatoid arthritis, scleroderma), and non-pharmacologic treatment of mycotic nails (onychomycosis), when Medically Necessary.

    In-Network. In-Network Benefits are subject to a $75 Copayment for Facility charges. Professional charges are covered at 100% of the Allowable Expense.

    Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

17. **Preventive Services Required by the Federal Patient Protection and Affordable Care Act.** The Program will provide coverage for the preventive services identified below. To the extent such items and services are covered elsewhere under this booklet, any cost-sharing provisions that may apply will not apply to any In-Network Benefit.

    A. **Evidence-Based Preventive Services.** Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the USPSTF issued in 2002 will be considered the current recommendations until further guidance is issued by the USPSTF or the Health Resources and Services Administration (HRSA);

    B. **Routine Immunizations.** Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention with respect to the individual involved;

    C. **Prevention for Children.** With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA.

D. **Prevention for Women.** With respect to women, such additional preventive care and screenings, not otherwise addressed by the USPSTF, as provided for in comprehensive guidelines supported by HRSA and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services).

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

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

Out-of-Network Benefits. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after Deductible.

18. **Qualified Clinical Trial Expenses.** The Benefit Plan 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 Covered Person's diagnosis; provided, such health care items and services would have been covered under the Benefit Plan 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, Coinsurance or Copayment provisions for similar services.

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.

2. **Eligibility for Benefits**. The Benefit Plan will provide coverage for care at the emergency room of a Participating Provider or a Non-Participating Provider if your illness or condition is considered an Emergency Condition. The Benefit Plan 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**.

   In-Network. In-Network Benefits are subject to a $75 Copayment.

   Out-of-Network. Out-of-Network Benefits are subject to a $75 Copayment.

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

   In-Network. In-Network Benefits for the Facility charges are subject to a $25 Copayment. In-Network Benefits for professional charges are covered at 100% of the Allowable Expense.

Out-of-Network. Out-of-Network for the Facility charges are subject to a $25 Copayment. Out-of-Network Benefits for professional charges are covered at 100% of the Allowable Expense.

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

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

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

SECTION TWELVE - HUMAN ORGAN AND BONE MARROW TRANSPLANTS

The Benefit Plan will provide coverage for all of the benefits otherwise covered under this Benefit Plan 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 Benefit Plan'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 Benefit Plan will provide coverage for an amount $500 less than the Benefit Plan would otherwise cover for the care, or the Benefit Plan will provide coverage for only 50% of the amount the Benefit Plan would otherwise have covered for the care, whichever results in a greater benefit to you. You must pay the remaining charges. The Benefit Plan 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 at the number on your member ID card if you wish to obtain a list of approved transplant centers.

3. **No Coverage of Experimental Or Investigational Organ Transplants.** The Benefit Plan 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 Benefit Plan. You may contact Excellus BlueCross BlueShield at the number on your member ID card if you have a question concerning whether a particular transplant procedure may be covered.

4. **Recipient Benefits.** The Benefit Plan will provide coverage for a person covered under this Benefit Plan for all of the benefits provided to the recipient of the organ transplant that are otherwise covered under the Benefit Plan when they result from or are directly related to a covered organ or bone marrow transplant.

5. **Coverage for Donor Searches or Screenings.** The Benefit Plan will not provide coverage for costs relating to searches or screenings for donors of organs.

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

SECTION THIRTEEN - PRESCRIPTION DRUG BENEFITS

Excellus BlueCross BlueShield is not the Claims Administrator for Prescription Drug benefits. The Claims Administrator for Prescription Drug benefits is ProAct Rx. Any questions regarding Prescription Drug coverage under the Benefit Plan should be directed to ProAct Rx or the Group.

Drugs from a Retail Participating Pharmacy. Prescription Drugs are available from a retail participating Pharmacy as follows:

(1) **Generic Drugs.** If you have a prescription filled with a Generic drug, you must pay the Pharmacy a $10 Copayment (for a 30-day supply). The Pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

(2) **Brand Name Drugs.** If you have a prescription filled with a Brand Name drug, you must pay the Pharmacy a $25 Copayment (for a 30-day supply). The Pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

(3) **Non-Preferred Drug.** If you have a prescription filled with a Non-Preferred drug, you must pay the Pharmacy a $45 Copayment (for a 30-day supply). The Pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

Drugs from a Mail Order Participating Pharmacy. Prescription Drugs are available from a mail order participating Pharmacy as follows:

(1) **Generic Drugs.** If you have a prescription filled with a Generic drug, you must pay the Pharmacy a $20 Copayment (for a 90-day supply). The Pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

(2) **Brand Name Drugs.** If you have a prescription filled with a Brand Name drug, you must pay the Pharmacy a $50 Copayment (for a 90-day supply). The Pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

(3) **Non-Preferred Drug.** If you have a prescription filled with a Non-Preferred drug, you must pay the Pharmacy a $90 Copayment (for a 90-day supply). The Pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

Specialty Drugs.

Effective Prior to January 1, 2019.

Specialty drugs are available from a designated Pharmacy as follows:

(1) **Generic Drugs.** If you have a prescription filled with a Generic drug, you must pay the Pharmacy a $10 Copayment (for a 30-day supply). The Pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

(3) **Brand Name Drugs.** If you have a prescription filled with a Brand Name drug, you must pay the Pharmacy a $25 Copayment (for a 30-day supply). The Pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

(3) **Non-Preferred Drug.** If you have a prescription filled with a Non-Preferred drug, you must pay the Pharmacy a $45 Copayment (for a 30-day supply). The Pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

Effective on or after January 1, 2019

Specialty drugs are available from a designated Pharmacy subject to 20% Coinsurance for up to a 30-day supply per prescription.

The Benefit Plan permits you to fill your specialty drug one (1) time at a retail Pharmacy. All subsequent orders must be filled at a designated Pharmacy. The designated Pharmacy for specialty drugs is Noble Health Services. If you do not fill your prescription at the designated Pharmacy after the first fill, no coverage for your specialty drug will be provided under the Benefit Plan. For more information regarding the specialty drug program, please contact Noble Health Services at 1.888.843.2040 or www.noblehealthservices.com.

Noble Health Services will act on your behalf in obtaining manufacturer co-pay assistance for certain specialty drugs covered under the Benefit Plan and the Cost-Sharing you pay under the Benefit Plan for certain specialty drugs will be reduced. For more information regarding this program, please contact Noble Health Services at 1.888.843.2040 or www.noblehealthservices.com.

Prescription Drugs from a non-participating Pharmacy are not covered.

Prescription Drug Charge
Participating pharmacies have contracted with the Benefit Plan to charge Members reduced fees for covered Prescription Drugs. ProAct, the Pharmacy Benefit Manager (PBM), is the administrator of the Prescription Drug benefits.

Copayments
The Copayment is applied to each covered Prescription Drug or mail order drug charge.

Any one Prescription Drug is limited to a 30-day supply for specialty drugs, 30-day supply at a retail Pharmacy or a 90-day supply at a mail order Pharmacy.

If a drug is purchased from a non-participating retail Pharmacy or a participating retail Pharmacy when the Member's ID card is not used, the amount payable in excess of the Cost-Sharing amount will be the ingredient cost and dispensing fee.

Percentages Payable
The percentage payable amount is applied to each covered Prescription Drug at the retail or mail order drug charge.

Mail Order Drug Benefit Option
The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order Pharmacy is able to offer Members significant savings on their prescriptions.

Preauthorization Requirements
Some drugs require preauthorization before benefits become available. The participating retail Pharmacy or mail order Pharmacy will not provide coverage unless drugs have been approved for benefit payment. If a Pharmacy advises you that you need preauthorization, you should call Customer Service Department at 1.866.287.9885 for assistance. Failure to obtain prior authorization will result in denial of benefits.

Quantity Limits
Some drugs have quantity limits. The participating retail Pharmacy or mail order Pharmacy will not provide coverage for drugs beyond those limits. You can call Customer Service Department at 1.866.287.9885 to determine if your drug has limitations.

Specialty Pharmacy Services
The PBM has a special program for specialty drugs developed for chronic and or complex illnesses including but not limited to Crohn's disease, hepatitis C, osteoarthritis, rheumatoid arthritis, infertility, and pulmonary disease. These drugs may have special handling storage, shipping requirements, or require disease specific treatment programs. They may be injections, infusions, or oral products.

All drugs deemed specialty drugs by the PBM and received by the PBM's mail order will be sent to the PBM's specialty Pharmacy to be filled. A complete list of drugs available under the specialty Pharmacy is available by calling the PBM's Customer Service Department's toll-free number: 1.866.287.9885 or you may access the list on their website at www.ProActrx.com.

Vacation Supply
A supply of medication may be replenished before a normal refill date when needed for a vacation trip. To obtain authorization for an advance supply of drugs, you must phone the PBM toll-free at 1.866.287.9885. This means that you may receive up to a 90-day supply, limit one fill per Calendar Year. You must pay the applicable multiple Copayments for a vacation supply.

Generic Drug Substitution Program
As part of a continuing effort to control costs and preserve the quality of the Benefit Plan, you are encouraged to use Generic Drugs whenever appropriate for your condition. A Generic Drug is chemically equivalent to the original Brand Name Drug. The only difference is that the Brand Name manufacturer's patent has expired, allowing other manufacturers to sell the drug. As a result, the Generic manufacturer does not incur research costs and can charge significantly less

for the drug. Since Generic Drugs cost less than Brand Name Drugs, cost savings result for you (a lower percentage payable liability amount) and the Benefit Plan when you substitute the lower priced drug. If you have any questions about Generic Drugs, ask for advice from your Physician or your pharmacist.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law, but excludes any drugs stated as not covered under this Benefit Plan. This includes all FDA-approved contraceptives that require a prescription for all Members.
(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
(3) Insulin and other diabetic supplies when prescribed by a Physician.
(4) Injectable drugs or any prescription directing administration by injection.
(5) Blood glucose monitors and test strips, lancet devices, insulin pump.

Limits to This Benefit

This benefit applies only when a Member incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.
(2) Refills up to one year from the date of order by a Physician.
(3) Quantity limits that could apply to controlled substances based on state regulations.

Expenses Not Covered

In addition to the general exclusions section of this Benefit Plan, the Benefit Plan will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.
(2) **Appetite Suppressants/Dietary/Vitamin Supplements.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
(3) **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed. Vaccinations are covered.
(4) **Devices.** Devices of any type, even though such devices may require a prescription, excluding Physician-prescribed contraceptive devices, unless as indicated above as a covered item. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
(5) **Drugs Used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
(7) **FDA.** Any drug not approved by the Food and Drug Administration.
(8) **Fluoride.** Dental fluoride products, except vitamin supplements containing fluoride prescribed for children to age five years.
(9) **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(10) **Immunization.** Immunization agents or biological sera. **Note:** Covered immunizations performed at the Pharmacy will allowed.
(11) **Infertility.** A charge for Infertility medication.
(12) **Injectable Supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).
(13) **Inpatient Medication.** A drug or medicine that is to be taken by the Member, in whole or in part, while Hospital confined. This includes being confined in any institution that has a Facility for the dispensing of drugs and medicines on its premises.
(14) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".
(15) **Medical Exclusions.** A charge excluded under the General Exclusions section of this Benefit Plan.
(16) **No Charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
(17) **No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or drugs indicated by the Plan (e.g. non-sedating anti-histamines).
(18) **Off Label Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
(19) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

SECTION FOURTEEN - GENERAL EXCLUSIONS

In addition to the exclusions and limitations described in other Sections of this Booklet, the Benefit Plan will not provide coverage for the following:

1. **Abortions.** The Benefit Plan will not provide coverage for elective abortions.

2. **Acupuncture.** The Benefit Plan will not provide coverage for acupuncture.

3. **Autism Spectrum Disorder.** The Benefit Plan will not provide coverage for autism spectrum disorder.

4. **Biofeedback.** The Benefit Plan will not provide coverage for biofeedback.

5. **Certification Examinations.** The Benefit Plan 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.

6. **Cosmetic Services.** The Benefit Plan 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 Benefit Plan 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 Benefit Plan also will provide coverage for reconstructive surgery because of congenital disease or anomaly of a child covered under this Benefit Plan that has resulted in a functional defect. The Benefit Plan also will provide coverage for services in connection with reconstructive surgery following a mastectomy, as provided in Section Nine.

7. **Court-Ordered Services.** The Benefit Plan 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 Benefit Plan in the absence of a court order;

   B. All applicable procedures have been followed to authorize the service or care; and

   C. The Medical Director determines, in advance, that the service or care is Medically Necessary and covered under the terms of this Benefit Plan.

   This exclusion also applies to any service or care (including evaluation, testing, and/or treatment) that an arbitrator, administrative tribunal, or a court orders in connection with litigation or other legal matters.

8. **Criminal Behavior.** The Benefit Plan 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).

9. **Custodial Care.** The Benefit Plan 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.

10. **Dental Care.** The Benefit Plan 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 Benefit Plan 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 Benefit Plan 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 Benefit Plan 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 Benefit Plan will also cover services for treatment of TMJ following diagnosis of TMJ. The Benefit Plan 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 Benefit Plan 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.

11. **Disposable Supplies; Household Fixtures.** The Benefit Plan will not provide coverage for any service or care related to:

    A. Disposable supplies (for example, diapers, chux, sponges, syringes, incontinence pads, reagent strips and bandages purchased for general use); except that this exclusion does not apply to diabetic supplies covered under Section Ten;

    B. The purchase or rental of household fixtures, including, but not limited to, elevators, escalators, ramps, seat lift chairs, stair glides, saunas, whirlpool baths, swimming pools, home tracking systems, exercise cycles, air or water purifiers,

hypo-allergenic pillows, mattresses or waterbeds, massage equipment, central or unit air conditioners, humidifiers, dehumidifiers, emergency alert equipment, handrails, heat appliances, improvements made to a house or place of business, and adjustments made to vehicles.

12. **Experimental and Investigational Services.** Unless otherwise required by law, the Benefit Plan will not provide coverage for any service or care that consists of a treatment, procedure, drug, biological product, or medical device (collectively, "Service"); an inpatient stay in connection with a Service; or treatment of a complication related to a Service; if, Excellus BlueCross BlueShield determines the Service is experimental or investigational.

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

A. Not of proven benefit for a particular diagnosis or for treatment of a particular condition;

B. Not generally recognized by the medical community, as reflected in published, peer-reviewed, medical literature, as effective or appropriate for a particular diagnosis or for treatment of a particular condition; or

C. Not of proven safety for a person with a particular diagnosis or a particular condition, i.e., is currently being evaluated in research studies to ascertain the safety and effectiveness of the treatment on the well-being of a person with the particular diagnosis or in the particular condition.

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

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

A. A Service that is a medical device, drug, or biological product must have received final approval of the United States Food and Drug Administration (FDA) to market for the particular diagnosis or for your particular condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once final FDA approval has been granted for a particular diagnosis or for your particular condition, use of the Service (medical device, drug, or biological product) for another diagnosis or condition may require that any or all of the five criteria be met.

B. Published, peer-reviewed, medical literature must provide conclusive evidence that the Service has a definite, positive effect on health outcomes. The evidence must include reports of well-designed investigations that have been reproduced by

nonaffiliated, authoritative sources with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

C. Published, peer-reviewed, medical literature must provide demonstrated evidence that, over time, the Service leads to improvement in health outcomes, i.e., the beneficial effects of the Service outweigh any harmful effects.

D. Published, peer-reviewed, medical literature must provide proof that the Service is at least as effective in improving health outcomes as established services or technology, or is usable in appropriate clinical contexts in which an established service or technology is not employable.

E. Published, peer-reviewed, medical literature must provide proof that improvement in health outcomes, as defined in Subparagraph C above, is possible in standard conditions of medical practice, outside of clinical investigatory settings.

This exclusion shall not limit in any way benefits available for prescription drugs otherwise covered under this Benefit Plan 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 if the Benefit Plan were subject to the New York Insurance Law.

13. **Free Care.** The Benefit Plan 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 Benefit Plan. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your spouse, brother, sister, mother, father, son or daughter; or the spouse of any of them; it will be presumed that the service or care would have been furnished without charge. You must prove that a service or care would not have been furnished without charge.

14. **Government Hospitals**. Except as otherwise required by law, the Benefit Plan 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 Benefit Plan will provide coverage for services or care in such a Facility to treat an Emergency Condition. In this case, the Benefit Plan 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.

15. **Government Programs.** The Benefit Plan 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 Benefit Plan 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 Benefit Plan 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, that is required by law to have this Benefit Plan 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 Benefit Plan will not reduce this Benefit Plan's benefits, and the Benefit Plan will provide benefits before Medicare pays, during the waiting period. The Benefit Plan 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 Benefit Plan.

16. **Impotency.** The Benefit Plan will not provide coverage for any services related to impotency.

17. **Infertility Treatment.** The Benefit Plan will not provide coverage for any service or care related to the treatment of infertility, including any of the following reproductive services: artificial insemination, in-vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cloning, sperm banking and donor fees associated with artificial insemination or other procedures.

18. **Military Service-Connected Conditions.** The Benefit Plan 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.

19. **No-Fault Automobile Insurance.** The Benefit Plan 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 Benefit Plan 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 Benefit Plan will provide coverage for the services covered under this Benefit Plan, up to the amount of the Deductible. The Benefit Plan 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.

20. **Non-Covered Service.** The Benefit Plan 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 Benefit Plan; even when an In-Network Provider considers the service or care to be Medically Necessary and appropriate.

21. **Personal Comfort Services.** The Benefit Plan 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.

22. **Prescription Drugs.** Prescription drugs are not covered under the Benefit Plan. Prescription drugs are covered under a separate plan or policy maintained by the Group.

23. **Private Duty Nursing Service.** The Benefit Plan 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.

24. **Reversal of Elective Sterilization.** The Benefit Plan will not provide coverage for the reversal of elective sterilization.

25. **Routine Care of The Feet.** The Benefit Plan will not provide coverage for services related to routine care of the feet, including but not limited to orthopedic and diabetic shoes, shoe inserts, corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, toenails, or symptomatic complaints of the feet.

26. **School System Services**. The Benefit Plan 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.

27. **Self-Help Diagnosis, Training and Treatment.** The Benefit Plan 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.

28. **Services Covered under Hospice Care**. If you have been formally admitted to a hospice program and the Benefit Plan is providing coverage for your hospice care, the Benefit Plan 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 Benefit Plan for a condition not covered under the hospice program, coverage will be available under this Benefit Plan for those covered services.

29. **Services Starting Before Coverage Begins.** If you are receiving care on the day your coverage under this Benefit Plan begins, the Benefit Plan will not provide coverage for any service or care you receive:

    Prior to the first day of your coverage under this Benefit Plan; or

    On or after the first day of your coverage under this Benefit Plan, 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.

30. **Special Charges.** The Benefit Plan 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.

31. **Unlicensed Provider.** The Benefit Plan 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.

32. **Vision and Hearing Therapies and Supplies.** The Benefit Plan will not provide coverage for any service or care related to:

    A. Hearing aids; and

    B. Eye wear, vision or hearing therapy, vision training, or orthoptics.

33. **Weight Loss Services.** The Benefit Plan will not provide coverage for any service or care in connection with weight reduction or dietary control, including, but not limited to, gastric stapling, gastric by-pass, gastric bubble, or any other surgery for the treatment of

obesity or morbid obesity, or weight loss programs, unless Medically Necessary.

34. **Workers' Compensation.** The Benefit Plan will not provide coverage for any service or care for which benefits are available to you under a workers' compensation or similar law. The Benefit Plan 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 Benefit Plan 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.

A. **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 Benefit Plan will coordinate benefit payments with any payment made under the other plan. Coordination of Benefits (COB) takes effect when a subscriber and their dependents have insurance other than this Benefit Plan. The general rule the Benefit Plan follows is that the subscriber and spouse are primary under their own respective contract. 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:

i. 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;

ii. Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;

iii. Any Blue Cross Blue Shield, or other service type group plan;

iv. 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

v. Medical benefits coverage in group or individual mandatory automobile "no-fault" or traditional "fault" type contracts.

B. **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:

i. If the other plan does not have a provision similar to this one, then it will be primary;

ii. 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

iii. 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.

iv. 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.

v. 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.

C. **Payment of the Benefit When this Benefit Plan is Secondary.** When this Benefit Plan is secondary, its benefits will be reduced so that the total benefits payable under the other plan and this Benefit Plan do not exceed your expenses for an item of service. However, this Benefit Plan will not pay more than it would have paid if it was primary.

This Benefit Plan uses a Coordination of Benefits (COB) methodology. The intent of COB 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 Benefit Plan is secondary, if the benefits of the primary plan are less than the normal benefits of this Benefit Plan, then this Benefit Plan will pay the difference between the primary plan's benefits and this Benefit Plan's normal benefit.

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

The Benefit Plan 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 Benefit Plan 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 Benefit Plan'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.

D. **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 or the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). 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.

E. **Payments to Others.** The Benefit Plan may repay to any other person, insurance company, or organization the amount which it paid for your covered services and which the Benefit Plan should have paid. These payments are the same as benefits paid.

F. **The Benefit Plan's Right to Recover Overpayment.** In some cases, the Benefit Plan may have made payment even though you had coverage under another plan. Under these circumstances, you must refund to the Group or the Benefit Plan the amount by which the Benefit Plan should have reduced its payment. The Group or the Benefit Plan 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 Benefit Plan recover any overpayment.

SECTION SIXTEEN - TERMINATION OF YOUR COVERAGE

Described below are the reasons why your coverage under this Benefit Plan may terminate. All terminations are effective on the date specified.

A. **Termination of the Benefit Plan.** Your benefits under the Benefit Plan may be terminated at any time, if the Group ends the Benefit Plan.

B. **Termination of Your Coverage Under the Benefit Plan.** In the following instances, the Benefit Plan will continue in force, but your coverage under the Benefit Plan will be terminated:

1. You choose to terminate your coverage due to availability of other coverage. You must give the County 31 days' written notice from start of new coverage. Your coverage will terminate at 12:01a.m. on the date the other coverage begins;

2. You are no longer a 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;

3. You make an intentional misrepresentation of material fact or commit fraud in applying for coverage or in filing a claim under this Benefit Plan;

4. Termination of the employee of the Group's marriage. If the employee of the Group becomes divorced, or the employee of the Group's marriage is annulled, coverage of the employee of the Group's former spouse under this Benefit Plan will automatically terminate on the date of the divorce or annulment. Employee is required to notify the Benefit Plan within 31 days of the divorce or annulment;

5. Termination of coverage of a child. Coverage of an employee of the Group's child under this Benefit Plan will terminate on the date the child no longer qualifies as a dependent under Section Two of this booklet; or

6. Termination as requested during open enrollment. If you request cancellation of your coverage during the open enrollment period, coverage ends for you and/or your dependents (as applicable) at 12:00a.m. on December 31st of that year.

C. **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.

D. **Continuation of Coverage due to an Approved Leave of Absence or Disability.**

There are certain situations where you can remain eligible for benefits, even though your status changes from that of an active employee or your employment terminates. They are:

1. If you are on an approved leave of absence without pay, you may remain part of the group by making direct payments for benefits to the Employee Benefits Division.

2. A surviving spouse and dependents enrolled in the Benefit Plan at the time of an employee's death will be eligible for benefits for 90 days from the date of death at no cost to the dependents. After that time, if the employee had ten or more years of service, the surviving spouse and dependents can maintain eligibility by completing an enrollment application and making direct premium payments.

3. If any employee dies and either an accidental death benefit is payable by a retirement or pension plan administered by New York State, or death benefits are payable under the Workers' Compensation Law of New York, all dependents may then continue benefits by making direct payments.

4. If an employee, enrolled under the **OnPoint** program, submits proof of total disability, has been disabled for at least 90 consecutive calendar days, and has made all required payments during time off the payroll, waiver of required contributions may then be allowed for a period of one year while the employee remains totally disabled. **You will be considered Totally Disabled if, as a result of an illness or an accidental injury, you are unable to engage in any gainful occupation for which you are reasonably fitted by education, training, or experience, and are not able to perform work of any kind for wage of profit.**

SECTION SEVENTEEN - GENERAL PROVISIONS

1. **No Assignment.** You cannot assign any benefits or monies due under the Benefit Plan to any person, corporation or other organization. Any assignment by you will be void. Assignment means the transfer to another person or to an organization of your right to the services provided under this Benefit Plan or your right to collect money from it for those services.

2. **Notice.** Any notice that the Group or the Claims Administrator give to you under this Benefit Plan will be mailed to your address as it appears on our records or to the address of the Group. If you have to give the Benefit Plan or the Claims Administrator any notice, it should be mailed to: 165 Court Street, Rochester, NY 14647.

3. **Your Medical Records.** In order to provide your coverage under this Benefit Plan, it may be necessary for the Group and/or the Claims Administrator 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 Benefit Plan, you automatically give the Group and/or the Claims Administrator permission to obtain and use those records for those purposes.

   The Group and the Claims Administrator agree to maintain that information in accordance with state and federal confidentiality requirements. However, you automatically give the Group and the Claims Administrator permission to share that information with the New York State Department of Health, quality oversight organizations and third parties with which the Group and the Claims Administrator contract to assist them in administering this Benefit Plan, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

4. **Who Receives Payment under this Benefit Plan.** Payments under this Benefit Plan for service provided by an In-Network Provider will be made directly by the Benefit Plan (or by the Claims Administrator on behalf of the Benefit Plan) to the provider. If you receive services from an Out-of-Network Provider, payment may be made to either you or the provider at the option of the Group or the Claims Administrator.

5. **Time to File Claims.** Claims for services under this Benefit Plan must be submitted for payment within 12 months after you receive the services for which payment is being requested.

6. **Time to Sue.** No action at law or in equity may be maintained against the Benefit Plan or the Claims Administrator to recover benefits under the Benefit Plan prior to the

expiration of 60 days after written submission of a claim for such benefits has been furnished to the Benefit Plan as required in this booklet. In addition, no legal action may be commenced or maintained to recover benefits under the Benefit Plan more than three (3) years after the date you received the service for which you want the Benefit Plan to pay.

7. **Venue for Legal Action.** If a dispute arises under this Benefit Plan, it must be resolved in Federal court or a court located in the State of New York. You agree not to start a lawsuit against the Benefit Plan or the Claims Administrator in a court anywhere else. You also consent to these courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order you to defend any action the Benefit Plan or Claims Administrator brings against you.

8. **Choice of Law.** All disputes relating to this Benefit Plan shall be governed by Federal law and, as applicable, the laws of the State of New York.

9. **Recovery of Overpayments.** On occasion a payment will be made when you are not covered, for a service that is not covered, or which is more than is proper. When this happens the Group and/or the Claims Administrator will explain the problem to you and you must return the amount of the overpayment within 60 days after receiving notification.

10. **Right to Offset.** If the Benefit Plan makes a claim payment to you or on your behalf in error or you owe the Benefit Plan any money, you must repay the amount you owe. If the Benefit Plan owes you a payment for other claims received, the Benefit Plan has the right to subtract any amount you owe to the Benefit Plan from any payment the Benefit Plan owes you.

11. **Continuation of Benefit Limitations.** Some of the benefits under this Benefit Plan are limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if your coverage status should change during the Calendar Year. For example, if your coverage status changes from covered family member to employee or member of the Group, all benefits previously utilized when you were a covered family member will be applied toward your new status as an employee or member of the Group.

12. **Subrogation.** The purpose of this Benefit Plan is to provide benefits for expenses that are not covered by another party. All payments made under this Benefit Plan are conditioned on the understanding that the Benefit Plan will be repaid (either through reimbursement or subrogation) for benefits that related to an illness, injury or health condition for which you (or your estate, legal guardian or legal representative), may have or assert for a tort or contractual recovery. Recovery rights apply to any sums you receive by settlement, verdict, or otherwise for the illness, injury or health condition.

This Benefit Plan is always secondary to any recovery you make from Worker's Compensation (no matter how the settlement or award is characterized for damages) and is always secondary to any automobile coverage for first party benefits.

If you assert a claim against or receive money from another responsible person or insurance company or other party in connection with an illness, injury or health condition for which you have received benefits under this Benefit Plan, you must contact the Group immediately.

The Benefit Plan will be subrogated to all claims, demands, actions and rights of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including your own). The amount of such subrogation will equal the total amount paid under the Benefit Plan arising out of the illness, injury or health condition that is the basis for any claim you (or your estate, legal guardian or legal representative) may have or assert. The Benefit Plan may assert its subrogation rights independently of you or it may choose to assert its reimbursement rights against your recovery.

The Benefit Plan has the right to reimbursement to the extent of benefits paid related to the illness, injury or health condition from any recovery you may receive from these sources regardless of how your recovery is characterized or regardless of whether medical expenses are specifically included in your recovery. The Benefit Plan shall recover the full amount of benefits advanced and paid for the illness, accident, or injury without regard to any claim or fault on your part.

The Benefit Plan's subrogation and reimbursement rights are a first priority lien on any recovery meaning the Benefit Plan is entitled to recover up to the full amount of benefits it has paid without regard to whether you (or your estate, legal guardian or legal representative) have been made whole or received full compensation for your other damages and without regard to any legal fees or costs that you (or your estate, legal guardian or legal representative) have paid or owe. In other words, the Benefit Plan's right of recovery shall not be reduced due to the "Double Recovery Rule", "Made Whole Rule", "Common Fund Rule" or any other legal or equitable doctrine. The Benefit Plan's right of recovery takes preference over any other claims against the recovery and is enforceable regardless of how settlement proceeds are characterized.

You (or your estate, legal guardian or legal representative or other person acting on your behalf) who receives the recovery funds from any person or party must hold the funds in constructive trust for the benefit of the Benefit Plan.

You agree to cooperate with the Benefit Plan's reimbursement and subrogation rights as the Benefit Plan may request and you agree not to prejudice the Benefit Plan's rights under this provision in any manner.

13. **Who May Change this Benefit Plan.** The Benefit Plan may not be modified; amended; or changed, except in writing, and signed by the Chief Operating Officer ("COO") of the Group or a person duly authorized in writing by the COO of the Group to make changes to this Benefit Plan. No employee; agent; or other person is authorized to interpret; amend; modify; or otherwise change the Benefit Plan 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 the COO of the Group or by a person duly authorized in writing by the COO of the Group.

14. **Changes in this Benefit Plan.** The Group may unilaterally change this Benefit Plan at any time in accordance with Section Seventeen.

15. **Agreements between the Claims Administrator and In-Network Providers.** Any agreement between the Claims Administrator and In-Network Providers may only be terminated by the Claims Administrator or the providers. This Benefit Plan and the Claims Administrator do not require any provider to accept a Member as a patient. Neither the Benefit Plan, nor the Group nor the Claims Administrator guarantees a Member's admission to any In-Network Provider or any health benefits program.

16. **Notice of Claim.** Claims for services under this Benefit Plan must include all information designated by the Group and/or the Claims Administrator as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, social security number, and supporting medical records, when necessary. A claim that fails to contain all necessary information may be denied.

17. **Identification Cards.** Identification cards are issued for identification only. Possession of any identification card confers no right to services or benefits under this Benefit Plan. To be entitled to such services or benefits the Member's contributions must be paid in full at the time that the services are sought to be received. Coverage under this Benefit Plan may be terminated if the Member allows another person to wrongfully use the identification cards.

18. **Right to Develop Guidelines and Administrative Rules.** The Group and/or the Claims Administrator may develop or adopt standards that describe in more detail when payment will or will not be made under this Benefit Plan. 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 that apply to a particular benefit, you may contact the Claims Administrator and it will explain the standards or send you a copy of the standards. The Group and/or the Claims Administrator may also develop administrative rules pertaining to enrollment and other administrative matters. The Group and/or the Claims Administrator shall have all the powers necessary or appropriate to enable them to carry out their duties in connection with the administration of their respective duties under this Benefit Plan.

19. **Furnishing Information and Audit.** All persons covered under this Benefit Plan will promptly furnish the Group and/or the Claims Administrator with all information and records that they may require from time to time to perform their obligations under this Benefit Plan. You must provide the Group and/or the Claims Administrator with information over the telephone for reasons such as the following: to allow the Group and/or the Claims Administrator to determine the level of care you need; so that the Group and/or the Claims Administrator may certify care authorized by your physician; or to make decisions regarding the Medical Necessity of your care.

20. **Enrollment.** The Group will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages and social security numbers of all group members covered under this Benefit Plan, and any other information required to confirm their eligibility for coverage. The Group will provide the Claims Administrator with the enrollment form including your name, address, age and social security number and advise the Claims Administrator in writing when you are to be added to or subtracted from our list of covered persons, on a monthly basis. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 30 days.

21. **Reports and Records.** The Group and the Claims Administrator are entitled to receive from any provider of services to Members, information reasonably necessary to administer this Benefit Plan subject to all applicable confidentiality requirements as defined in the General Provisions Section of this booklet. By accepting coverage under this Benefit Plan, the employee or member of the Group, for himself or herself, and for all family members covered hereunder, authorizes each and every provider who renders services to a Member hereunder to:

    A. Disclose all facts pertaining to the care, treatment and physical condition of the Member to the Group and/or the Claims Administrator, or a medical, dental, or mental health professional that the Group and/or the Claims Administrator may engage to assist the Group and the Claims Administrator 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 Member to the Group and/or the Claims Administrator, or a medical, dental, or mental health professional, that the Group and/or the Claims Administrator may engage to assist the Group and the Claims Administrator in reviewing a treatment or claim; and

    C. Permit copying of the Member's records by the Group and the Claims Administrator.

22. **Services will not be Denied Based on Gender Identity**. The Benefit Plan 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 Benefit Plan 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.

23. **Service Marks.** Excellus Health Plan, Inc. ("Excellus") is an independent corporation organized under the Insurance Law of New York State. Excellus also operates under licenses with the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans, which licenses Excellus to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus does not act as an agent of the Blue Cross and Blue Shield Association. Excellus is solely responsible for its obligations created under the Administrative Services Contract between the Group and Excellus.

24. **Inter-Plan Arrangements Disclosure - Out-of-Area Services.** The Claims Administrator 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 Claims Administrator's 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. The Claims Administrator'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, the Claims Administrator 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 Claims Administrator's 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 the Claims Administrator. 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 result 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 the Claims Administrator 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, the Claims Administrator 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 the Claims Administrator's Service Area.** The Allowable Expense definition in this booklet, as amended from time-to-time, describes how the Claims Administrator'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 the Claims Administrator 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 Benefit Plan.

25. ****IMPORTANT: THIS PARAGRAPH 25 DOES NOT APPLY TO PRESCRIPTION DRUG COVERAGE UNDER THE BENEFIT PLAN. FOR GREIVANCE PROCEDURES FOR PRESCRIPTION DRUG COVERAGE, PLEASE REVIEW THE MATERIALS PROVIDED BY PROACTRX OR CONTACT PROACTRX AT 1.866.287.9885 OR WWW.PROACTRX.COM****

Grievance Procedures. A grievance procedure has been established to resolve Member grievances. These procedures make sure that your questions, concerns, and complaints are resolved in a timely, fair manner.

A. **Filing a Grievance.** The Grievance Procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination. Appeals regarding those decisions are handled pursuant to paragraph 25. To initiate a grievance, just contact the Claims Administrator. The Claims Administrator keeps all requests and discussions confidential and it will take no discriminatory action because of your issue. The Claims Administrator has a process for both standard and expedited grievances, depending on the nature of your inquiry. It maintains a file on each grievance.

You can either contact the Claims Administrator by phone, in person or in writing to file a grievance. You or your designee has up to 180 calendar days from when you received the decision to file the grievance.

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

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

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

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

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

B. Notice of Determination. The notice of determination of your grievance will include detailed reasons for the determination and, if a clinical matter is involved, the clinical rationale, or a written statement that insufficient information was presented or available to reach a determination, and further appeal rights, if any. The Claims Administrator will send notices to you or your representative and to your health care provider.

26. ****IMPORTANT: THIS PARAGRAPH 26 DOES NOT APPLY TO PRESCRIPTION DRUG COVERAGE UNDER THE BENEFIT PLAN. FOR UTILIZATION REVIEW AND APPEAL PROCEDURES FOR PRESCRIPTION**

DRUG COVERAGE, PLEASE REVIEW THE MATERIALS PROVIDED BY PROACTRX OR CONTACT PROACTRX AT 1.866.287.9885 OR WWW.PROACTRX.COM**

Utilization Review. The Claims Administrator reviews proposed and rendered health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being rendered (prospective); when the service is being rendered (concurrent); or after the service is rendered (retrospective).

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

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

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

With respect to urgent prospective claims, if the Claims Administrator has all information necessary to make a determination, it will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 72 hours of receipt of the request. If the Claims Administrator needs additional information, it will request it within 24 hours. You or your

provider will then have 48 hours to submit the information. The Claims Administrator will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of its receipt of the information or the end of the 48-hour time period. A claim or other matter is "urgent" if it could seriously jeopardize your life or health or the ability to regain maximum function; or if your provider determines it is urgent, it must be treated as such.

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

For concurrent reviews that involve urgent matters, the Claims Administrator will make a determination and provide notice to you (or your designee) and your provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified above for prospective urgent claims. If the Claims Administrator has approved a course of treatment, the Claims Administrator will not reduce or terminate the approved services unless you have been given enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

D. **Retrospective Reviews.** At the Claims Administrator's option, a nurse will review retrospectively the Medical Necessity of claims that are subject to Utilization Review. If the nurse determines that care you received was Medically Necessary, the nurse will authorize the benefits. If the nurse determines that Medical Necessity was lacking, the nurse will refer the case to a licensed physician.

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

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

F. **Internal Appeals of Adverse Determinations.** You, your designee, and/or your health care provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing. You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. The Claims Administrator will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will review the appeal.

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

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

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider

requests an immediate review, or any other urgent matter, will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews. For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request.

If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal.

G. **Notice of Determination of Internal Appeal.** The notice of determination of your internal appeal will indicate that it is a "final adverse determination" and will include the clinical rationale for the Claims Administrator's decision. It will also explain your rights to an external appeal. Notices of determination will be sent to you or your designee and to your health care provider.

H. **Your Right to an Immediate External Appeal.** If the Claims Administrator fails to adhere to the utilization review requirements described above, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external appeal as described in paragraph 26 below. However, you will not be deemed to have exhausted the internal process if the Claims Administrator makes a minor error which is beyond its control or due to good cause, is made in the context of an ongoing good faith exchange of information and does not reflect a pattern or practice of non-compliance.

27. **External Appeal.**

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

You may have the right to an expedited external appeal if the timeframe for completion of an expedited internal appeal or a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function. Also, you have the right to an expedited external appeal in connection with final adverse determinations concerning an admission, availability of care, continued stays, or health care services for which you received emergency services, but have not been discharged from a facility. If coverage is denied on the basis that the requested service is experimental or

investigational, and your treating physician certifies that the requested service would be significantly less effective if not promptly initiated, you may request an expedited external appeal. The timeframes for determining expedited external appeals are shorter than the timeframes for standard external appeals.

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

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

To be eligible for external appeal, the final adverse determination issued through the first level of the internal appeal process must be based on a determination that the requested service does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or that the requested service is experimental or investigational or for a rescission of coverage. For purposes of this section a rescission of coverage is a retroactive termination of coverage under the Claims Administrator, except in cases where You fail to pay any required contribution to the cost of coverage under the Claims Administrator. You do not have the right to an external appeal of any other determinations, even if those other determinations affect your coverage.

D. **Requesting an External Appeal.** If you meet the conditions described above, you or your authorized representative may request an external appeal by completing and filing a self-insured external appeal application with the Claims Administrator. The Claims Administrator will send the external appeal application to you with the notice of final adverse determination. You or your authorized representative will have the opportunity to submit additional information on the requested service; and you may be required to authorize the release of any medical records needed to reach a decision on the external appeal.

You must file your request for an external appeal with the Claims Administrator within four months of receiving a final adverse determination.

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

D. **Effect of the IRO's Decision.** The IRO's decision on your external appeal is binding on both parties, except to the extent other remedies are available under state or federal law.

E. **Questions.** If you do not understand any part of the external appeal process or if you have questions regarding your right to external appeal, you may contact the Employee Benefits Security Administration at 1-866-444-3272.

EXHIBIT A

July 1, 2017

UTILIZATION MANAGEMENT STANDARD CLINICAL REVIEW PREAUTHORIZATION LIST

Preauthorization means that you or the physician in charge of your care must notify the Claims Administrator in advance of plans for you to undergo a specific course of care (such as a hospital admission, or a complex diagnostic test) so that a determination can be made with respect to whether or not such care is Medically Necessary. These services require preauthorization regardless of whether the service is provided while you are in the hospital, in an outpatient department, in your doctor's office or at home.

Be aware that this document includes medical and technical language. **That's why it is important for you to review this information with your health care provider if you have questions**.

Payment is based on the terms and conditions of the Benefit Plan, eligibility and Medical Necessity at the time of service. Claims will process according to the terms and conditions of the Benefit Plan on the date of service. Failure to obtain the necessary preauthorization may result in the denial of the claim.

NOTE: The Benefit Plan does not include coverage for all benefits listed in this chart. **Please call the Customer Care phone number listed on your identification card to verify specific coverage requirements before having services rendered if you have any questions.**

Clinical Review Preauthorization Requirements	
Abdominoplasty and Panniculectomy	Required
Ablative techniques for treating Barrett's Esophagus and treating primary and metastatic liver malignancies	Not Required
Acoustic Cardiography	Required
Adenoidectomy	Not Required

Clinical Review Preauthorization Requirements	
Air Ambulance (Non-Emergent)	Required
Anesthesia for Dental Surgery	Required
Aqueous Drainage Devices	Required
Balloon Sinuplasty	Required
Bariatric Procedures	Required
BRCA Testing	Required
Blepharoplasty	Required
Breast Reconstruction, including but not limited to Implant Insertion, Removal, Reinsertion (except for breast cancer diagnosis)	Required
Breast Reduction Surgery, including surgery for Gynecomastia	Required
Cardiac Catheterization (elective)	Not Required
Cardiac Devices; Implantable	Required through **eviCore Healthcare**
Cardiovascular Telemetry Devices, Wearable; Mobile	Required
Chelation Therapy	Required
Cholecystectomy, Laparoscopic	Required

Clinical Review Preauthorization Requirements	
Clinical Trials *	Required
Cochlear Implants and Auditory Brain Stem Implants	Required
Collagenase; Clostridium Histolyticum; Xiaflex	Required
Comfort; Convenience, Cosmetic or Custodial Services or Procedures	Required
Compression Garments	Not Required
Computer Assisted Navigation for Knee and Hip Arthroscopy	Required
Contact Lenses	Not Required
Contact Lenses; Gas Permeable Scleral	Required
Cosmetic Services (refer to published procedure code list)	Required
Cranial Orthotics	Required
Cryosurgical Tumor Ablation	Required
Deep Brain Stimulation	Required
Dermabrasion	Required

Clinical Review Preauthorization Requirements	
Durable Medical Equipment	Required for all equipment listed below if covered under the Benefit Plan: • Airway Clearance Devices • Ambulatory Traction Devices • BiPAP / CPAP Machines • Bone Growth Stimulators • Continuous Glucose Monitoring Systems • Functional Neuromuscular Stimulators • Gait Trainers • Hospital Beds (including Air Fluidized Beds) • Insulin Pumps • Intrapulmonary Percussive Devices • Pneumatic Cervical Traction Devices • Pneumatic Compressors (Lymphedema Pumps) • Speech Generating Devices • Stander / Standing Devices • T.E.N.S. units • Wheel Chairs and Power Operated Vehicles • Wound Vac
Enteral and Parenteral Therapy	Not Required
Experimental and Investigational Procedures and /or Services	Required

Clinical Review Preauthorization Requirements	
Gastric Neurostimulation	Required
Genetic Testing	Required
Hearing Aids and Services	Not Required
Home Care and Home Infusion Nursing Visits	Required
Home Tele-Monitoring (this is not Cardiac Surveillance)	Not Covered
Home Uterine Monitoring	Required
Hospice Services	Not Required
Hospital to Hospital Transfers	Required
Hyperbaric Oxygen Therapy	Required
Hyperhidrosis Surgery	Required
Hysterectomy (excludes primary female reproductive cancer diagnosis)	Required
Inpatient Admissions (except routine maternity) to any facility including hospital, elective and direct admit, acute rehab, SNF, mental health, chemical dependency and hospital to hospital transfers. * Emergency admissions require notification to the Plan.	Required
Inpatient Admission to the Neonatal Intensive Care Unit (NICU)	Required

Clinical Review Preauthorization Requirements	
Joint Surgery Procedures including Replacement: Ankle, Elbow, Hip, Interphalangeal, Knee, Metacarpophalangeal, Shoulder, Wrist	Hip Knee Shoulder
Keloid Scar Revision	Required
Left Ventricular Assist Devices (LVAD)	Required
Lung Volume Reduction Surgery	Not Required
Magnetic Esophageal Ring for treatment of GERD	Required
Maze Procedure for treatment of Atrial Fibrillation	Not Required
Medical Specialty Drugs reference ExcelluBCBCs.com/provider for frequently updated list	Required
Miscellaneous and Unlisted Codes	Required
Muscle Flap Procedures	Not Required
Neuromuscular Stimulation for Scoliosis and electrical shock units	Required
Neuropsychological Testing	Required

Clinical Review Preauthorization Requirements	
Orthopedic / Orthotic Devices	Required for custom knee braces and cranial orthotics only
Osteochondral Bone Graft	Required
Otoplasty	Required
Pain Management Services	Not Required
Palatopharyngoplasty/ Uvulopalatopharyngoplasty	Required
Personal Care Services	Not Covered
Platelet Rich Plasma for wound healing, each unit	Required
Prolotherapy	Required
Prosthetic Devices	Required for: • Computerized prosthetic legs; legs • Miscellaneous and Unlisted "L" codes, or unless contract limitations apply "C"

Clinical Review Preauthorization Requirements	
Radiology (Imaging) Services (excludes imaging performed in the inpatient, observation and emergency room settings)	Refer to Radiology CPT code list: • CTs and CTAs • MRAs • MRIs • Nuclear cardiology • All PET scans (Positron Emission Tomography) Miscellaneous or unlisted radiology procedure codes
Radiation Therapy Including but not limited to IMRT, SRS and Proton Beam Therapies	Required through **eviCore Healthcare**
Refractive Procedures	Required
Rhinoplasty	Required
Sacral Nerve Stimulation for Pelvic Floor Dysfunction	Required
Septoplasty	Required
Sexual Reassignment Surgery	Required
Skin Substitutes	Required
Sleep disorders; surgical management of	Required
Sleep Disorder Management includes Sleep Studies, PAP Devices and Supplies	Required through **eviCore Healthcare**

Clinical Review Preauthorization Requirements	
Spine Surgery Program	Required for all procedures listed below regardless of place of service: • Allograft for Spine Surgery • Arthrodesis / Fusion • Arthroplasty; Artificial Disc • Autograft for Spine Surgery • Decompression Procedure(s); Spine • Discectomy including Osteophytectomy • Intraspinous Distraction (X-Stop) • Kyphoplasty • Laminectomy • Laminotomy/Laminectomy; percutaneous • Minimally Invasive Technique for Lumbar Fusion • Vertebral Corpectomy • Vertebroplasty Percutaneous
Spinal Cord Stimulation	Required
Stereotactic Radiosurgery (SRS)	Required
Therapy; Occupational	Required

Clinical Review Preauthorization Requirements	
Therapy; Physical	Required
Therapy; Speech	Required
Tonsillectomy	Not Required
Transplants	Required
Transportation	Not Required
Vagus Nerve Stimulation	Required
Varicose Vein Treatment Procedures (including, but not limited to: Vein Ligation, Sclerosing Injection, VNUS and Laser procedures)	Required
Vision Services Eyewear	Not Required
Vision Therapy	Required
Wound Filler	Not Required
Yttruim-90 ; Selective Internal Radiation Therapy (SIRT)	Required