



These are your
COLGATE UNIVERSITY PLAN BENEFITS

This booklet explains the benefits available to you under the self-funded health benefits program, maintained by Colgate University (the “Benefit Plan”). The Benefit Plan is funded by Colgate University (the “Group”). Excellus Health Plan, Inc. is the Claims Administrator for the Benefit Plan. Excellus Health Plan, Inc. is not acting as an insurer of your benefits. You should keep this booklet with your other important papers so it is available for your future reference.

This Benefit Plan offers each person the option to receive covered services on two benefit levels:

In-Network Benefits. In-Network Benefits are the highest level of coverage available. In-Network Benefits apply when your care is provided by In-Network Providers. When you receive In-Network Benefits, in addition to the Deductible that applies to certain In-Network Benefits, you will also be responsible for Coinsurance for certain health care services. You should always consider receiving health services first through In-Network Providers.

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 Out-of-Network Providers. When you receive Out-of-Network Benefits, you will incur the highest out-of-pocket expenses because in addition to any applicable Deductible and Coinsurance, you will be responsible 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, 2014. Under the Benefit Plan, the benefits described in this booklet will be provided to employees or members of the Group and their covered family members, subject to eligibility requirements. You should keep this booklet with your other important papers so that it is available for your future reference.
2. **Definitions.**
 - A. **Allowable Expense.** “Allowable Expense” means the maximum amount payable for covered services under this Benefit Plan, before any applicable Deductible and Coinsurance amounts are subtracted. The Allowable Expense is determined as follows:
 - (1) **Facility Services**
 - (a) The Allowable Expense for covered services received from an In-Network Facility is the amount set by state or federal law. In the absence of state or federal law, the Allowable Expense for an In-Network Facility will be the amount the Claims Administrator has negotiated with the In-Network Facility or the amount approved by another Blue Cross and Blue Shield Plan. However, when the In-Network Facility’s charge is less than the amount that the Claims Administrator has negotiated with the In-Network Facility, your Deductible or Coinsurance amount will be based on the In-Network Facility’s charge.
 - (b) The Allowable Expense for an Out-of-Network Facility (other than an Out-of-Network Facility providing services for an Emergency Condition) will be the lowest of:
 - (i) The amount the Claims Administrator (or a contractor, acting on the Claims Administrator’s behalf) has negotiated with the Out-of-Network Facility;
 - (ii) The average amount the Claims Administrator has negotiated with In-Network Facilities of the same type as the Out-of-Network Facility;
 - (iii) The amount provided to the Claims Administrator by another Blue Cross and Blue Shield Plan; or
 - (iii) The Facility’s charge.

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

- (iv) The Out-of-Network Service Provider's charge.
- (3) The Allowable Expense for services rendered by an Out-of-Network Facility or an Out-of-Network Service Provider in connection with an Emergency Condition is the Out-of-Network Facility's or Out-of-Network Service Provider's charge.
- B. **Calendar Year.** The 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.
- C. **Coinsurance.** A charge, expressed as a percentage of the Allowable Expense, that you must pay for certain services covered under this Benefit Plan. You are responsible for the payment of any Coinsurance directly to the provider.
- D. **Copayment.** A charge, expressed as a fixed dollar amount that you must pay for certain health services covered under this Benefit Plan. You are responsible for the payment of any Copayments directly to the provider when you receive health services.
- E. **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.)
- F. **Effective Date.** The date your coverage under this Benefit Plan begins. Coverage begins at 12:01 a.m. on the Effective Date.
- G. **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.

- H. **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.

- I. **Facility.** A Hospital; ambulatory surgery facility; birthing center; dialysis center; rehabilitation facility; hospice; home health agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; an 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; an institutional provider of chemical dependence and abuse treatment certified by the Office of Alcoholism and Substance Abuse Services (“OASAS”); other provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable); 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.

- J. **Hospital.** Any short-term acute general hospital facility that is accredited as a hospital by JCAHO; is certified under Medicare; and, if located in New York State, is licensed pursuant to Article 28 of the Public Health Law of New York. A Hospital is a licensed institution primarily engaged in providing:
 - (1) Inpatient diagnostic and therapeutic services for surgical and medical diagnosis;
 - (2) Treatment and care of injured and sick persons by or under the supervision of physicians; and
 - (3) Twenty-four (24) hour nursing service by or under the supervision of registered nurses.

None of the following are considered Hospitals:

- (1) Places primarily for nursing care;
- (2) Skilled Nursing Facilities;
- (3) Convalescent homes or similar institutions;
- (4) Institutions primarily for: custodial care; rest; or as domiciles;
- (5) Health resorts; spas; or sanitariums;
- (6) Infirmaries at schools; colleges; or camps;
- (7) Places primarily for the treatment of chemical dependence and abuse; hospice care; or rehabilitation; and
- (8) Free standing ambulatory surgical centers.

K. **In-Network Benefits.** In-Network Benefits is the highest level of coverage available. In-Network Benefits apply when your care is provided by In-Network Providers.

L. **In-Network Provider.** A Facility, Professional Provider or Provider of Additional Health Services that has a PPO provider agreement with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan to provide health services to Members. The Claims Administrator has provider directories that list all of the In-Network Providers within the Service Area. Copies of the directory of In-Network Providers within the Service Area are available free of charge upon request. Information is available for other Blue Cross and/or Blue Shield Plan providers at www.bcbs.com.

M. **Medical Director.** The person(s) designated by the Claims Administrator to monitor quality of care and appropriate utilization of health services.

N. **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.

O. **Medical Necessity.** See Section Three.

P. **Member.** Any employee or member of the Group and any eligible family member who meets all applicable eligibility requirements, for whom the required payment has actually been received by the Claims Administrator or the Group, and who is covered under this Benefit Plan.

Q. **Mental Illness.** A mental, nervous or emotional condition that the Claims Administrator 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.
- R. **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 Out-of-Network Providers. When you receive Out-of-Network Benefits, you will incur higher out-of-pocket expenses. In addition to any applicable Deductible and Coinsurance, you will be responsible for paying any difference between the Allowable Expense and the provider's charge.
- S. **Out-of-Network Provider.** A Facility, Professional Provider or Provider of Additional Health Services that does not have a PPO provider agreement with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan to provide health services to Members.
- T. **Preferred Provider Organization (PPO).** A network of Facilities, Professional Providers and Providers of Additional Health Services that have PPO provider agreements with the Claims Administrator or another Blue Cross and/or Blue Shield Plan to provide health services to Members.
- U. **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.
- V. **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 the Claims Administrator for payment under this Benefit Plan.

- W. **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.
- X. **Service Area.** The geographic area in which the Claims Administrator contracts with Facilities, Professional Providers and Providers of Additional Health Services to provide health services to Members. The Service Area consists of the following counties: Broome; Cayuga; Chemung; Chenango; Clinton; Cortland; Delaware; Essex; Franklin; Fulton; Hamilton; Herkimer; Jefferson; Lewis; Livingston; Madison; Monroe; Montgomery; Oneida; Onondaga; Ontario; Oswego; Otsego; St. Lawrence; Schuyler; Seneca; Steuben; Tioga; Tompkins; Wayne; and Yates.
- Y. **Skilled Care.** A service that the Claims Administrator 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.

- Z. Skilled Nursing Facility.** A facility accredited as a Skilled Nursing Facility by JCAHO or qualified as a Skilled Nursing Facility under Medicare. Coverage will be provided for your care in a Skilled Nursing Facility only if the Claims Administrator determines that the care is Skilled Care.

- AA. “You”, “Your” and “Yours”.** Throughout this booklet, the words “you”, “your” and “yours” refers to you, the employee or member of the Group to whom this booklet was issued. If other than individual coverage applies, then in most cases the words “you”, “your” and “yours” 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 or member 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. The term “spouse” means a person of the same or opposite gender that is legally married to you, the employee, and who is recognized as a spouse in accordance with the laws of the State of New York.
 - B. Your domestic partner. Domestic partner includes an unmarried person of the same or opposite sex that is at least 18 years old and not related to you, the employee, by marriage or blood in a way that would bar marriage. You and your domestic partner must reside together in a committed relationship and have been each other’s sole domestic partner for at least six months. In order to prove the existence of a domestic partnership, all of the following criteria must be met:
 - (1) **Economic Interdependence.** The partners must be economically interdependent upon each other. This may be proven by:
 - i. Registration as the employee’s domestic partner, if living in a city or county providing for registration of domestic partners, and providing a copy of the appropriate certificate to the Benefit Plan; or
 - ii. Submission to the Benefit Plan of a signed affidavit, in a form acceptable to the Group, confirming an existing and established relationship of intended future duration that involves economic interdependency.
 - (2) **Proof of Cohabitation.** The partners must prove that they are cohabitating. Cohabitation may be proved by presenting documentation, such as drivers’ licenses or tax returns, demonstrating that the partners are living together.
 - (3) **Other Indicia.** At least two other indicia of a domestic partnership must be provided: (i) a joint bank account; (ii) a joint credit or charge card; (iii) a joint obligation on a loan; (iv) status as authorized signatory on the partner’s bank account, credit card or charge card; (v) joint ownership or holding of investments; (vi) joint ownership of residence; (vii) joint ownership of real estate other than residence; (viii) listing of both partners as tenants on a lease of the shared residence; (ix) shared rental payments of a residence (need not be shared 50/50); (x) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence; (xi) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills), which need not be shared 50/50; (xii) shared household budget for purposes of

receiving government benefits; (xiii) status of one as representative payee for the other's government benefits; (xiv) joint ownership of major items of personal property (e.g., appliances, furniture); (xv) joint ownership of a motor vehicle; (xvi) joint responsibility for child-care (e.g., school documents, guardianship); (xvii) shared child-care expenses (e.g., baby-sitting, day care, school bills), which need not be shared 50/50; (xviii) execution of wills naming each other as executor or beneficiary; (xix) designation as beneficiary under the other's retirement benefits account; (xx) mutual grant of durable power of attorney; (xxi) affidavit by creditor or other individual able to testify to partners' financial interdependence; (xxii) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

- C. Your child who is under the age of 26. Coverage lasts until the date the child turns age 26. Your child need not be: financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as students; or unmarried. A spouse of a child is not covered.
- D. Your unmarried 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 request proof as to whether or not your child continues to qualify under this provision.

The term "child" includes: your natural child; legally adopted child; step child; a child of a domestic partner, 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.

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 family members as they pertain to eligibility for coverage under this Benefit Plan.

- 2. **Newborn Child.** If you have a type of coverage that would cover a newborn, your newborn child will be covered at birth, provided you notify the Group within 30 days of the birth by completing the enrollment form to add the child to your coverage. If you are changing your type of coverage (for example, from individual to family coverage) in order to cover the newborn child, you must complete the enrollment form and submit it to the Group, to expand your coverage to include your child within 30 days of the birth. If you do not submit the form to the Group within 30 days of the birth, coverage of the child will not become effective until the date to which the Group's next open enrollment period applies. If a child of yours who is covered under this Benefit Plan gives birth, your newborn grandchild will not be covered (unless you are appointed legal guardian or

granted legal custody of such child). In this case your grandchild will be covered the same as any other child in accordance with Subparagraph 1.C and D above).

3. **Adopted Newborns.** If you have a type of coverage that will cover a newborn, or switch to a type of coverage that will cover a newborn, coverage will be available for a proposed, adopted newborn from the moment of birth, if you, the proposed adoptive parent:
 - A. Notify the Group in accordance with paragraph 2 above; and
 - B. Take physical custody of the infant as soon as the infant is released from the Hospital after birth; and
 - C. File a petition within 30 days of the infant's birth pursuant to §115-C of the New York State Domestic Relations Law or a comparable provision when the child is adopted in another state.

Coverage under the Benefit Plan will not be provided, however, for the initial Hospital stay of an adopted newborn, if one of the child's natural parents has a benefit plan available to cover the newborn's initial Hospital stay. Coverage under the Benefit Plan will also not be provided for the newborn if a notice of revocation of the adoption has been filed or one of the natural parents revokes consent to the adoption. If the Benefit Plan provides coverage of an adopted newborn and notice of the revocation of the adoption is filed or one of the natural parents revokes their consent, the Benefit Plan will be entitled to recover any sums paid by it for care of the adopted newborn.

4. **Types of Coverage Offered under the Benefit Plan.** In addition to individual coverage, the following types of coverage are offered under this Benefit Plan:
 - A. **Family Coverage.** If family coverage applies, then you, the employee or member of the Group, and your spouse or domestic partner, and your child or children as described in Subparagraph 1.C and D above are covered.
 - B. **Spousal Coverage.** If spousal coverage applies, then only you, the employee or member of the Group, and your spouse or domestic partner as described in Subparagraph 1.A and B above are covered.
 - C. **Child(ren) Coverage.** If Child(ren) coverage applies, then only you, the employee or member of the group, and your child or children as described in Subparagraph 1.C and D above are covered.

The names of all persons covered under this Benefit Plan must have been specified on the enrollment form for this Benefit Plan or provided to the Group as described in paragraph 7 below. No one else can be substituted for those persons. The Group and the Claims Administrator have administrative rules to determine which types of coverage are available to employees and members of the Group. You are only entitled to the types of

coverage for which the Group (or the Claims Administrator on behalf of the Group) receives your contribution and that the Group's and the Claims Administrator's records indicate is applicable. You may call the Group or the Claims Administrator if you have any questions about which type of coverage applies to you.

5. **When Coverage Begins.** Coverage under this Benefit Plan will begin as follows:
 - A. If you, the employee or member of the Group, elect coverage before becoming eligible for coverage or within 30 days of becoming eligible, coverage begins at 12:01 a.m. on the date you become eligible.
 - B. If you, the employee or member of the Group, do not elect coverage upon becoming eligible or within 30 days of becoming eligible, you must wait until the Group's next open enrollment period, except as provided in paragraph 6 below. When you enroll during the next open enrollment period, coverage then begins at 12:01 a.m. on the date to which the open enrollment period applies.
 - C. If you, the employee or member of the Group, marry or enter into a domestic partnership while covered, and the Group receives notice of the marriage or domestic partnership within 30 days thereafter, coverage for your spouse or domestic partner starts at 12:01 a.m. on the date of your marriage or commencement of the domestic partnership. If the Group does not receive notice of the marriage or domestic partnership within the 30-day period; and, if you are changing from individual to family or spousal coverage, and the Claims Administrator does not receive a completed change of coverage form; your spouse or domestic partner must wait until the next open enrollment period for coverage. When your spouse or domestic partner is enrolled during the next open enrollment period, coverage for your spouse or domestic partner will start at 12:01 a.m. on the date to which the open enrollment period applies.
6. **When You Reject Initial Enrollment or Elect Not to Enroll During Open Enrollment, but Do Not Need to Wait until the Group's Next Open Enrollment Period to Enroll for Coverage.** If you, the employee or member of the Group, reject initial enrollment under this Benefit Plan, or elect not to enroll during a subsequent open enrollment, 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 or domestic partner;
 - (4) Legal separation, divorce or annulment, or termination of a domestic partnership;
 - (5) Reduction in the number of hours worked;
 - (6) The employer or other group ceased its contribution toward the premium for the other plan or contract;
 - (7) The coverage was under an HMO, and you no longer live, work or reside in the HMO service area;
 - (8) Cessation of eligible child status;
 - (9) Benefits are no longer offered to similarly situated individuals (e.g., part-time employees); or
- C. You acquire a family member due to birth, guardianship, adoption, placement for adoption, marriage, or commencement of a domestic partnership, in which case, you, the employee or member of the Group, may enroll for individual coverage or for a type of coverage available to your Group that will cover you and your eligible family members.
- 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 30 days after termination for one of the reasons set forth in Subparagraph B above, or acquisition of a family member as set forth in Subparagraph C above; or you apply for coverage under this 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 of marriage.

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

- A. **To Add a Spouse, Domestic Partner or Child.** If you need to add a spouse, domestic partner or child to your coverage (other than a newborn child added under paragraph 2 or 3 above), you must complete and return to the Group a form for this purpose and any requested documentation. The addition of a spouse, domestic partner or child will be effective as of the date of marriage, commencement of the domestic partnership or the adoption or other event making the child eligible for coverage under paragraph 1, if you return to the Group a completed application and requested documents within 30 days of the marriage, commencement of the domestic partnership, or the adoption or other event, and the applicable contribution is paid. If you do not return a completed form and documentation within the 30-day period described above, your spouse, domestic partner or child will be added to your coverage after the next open enrollment period, so long as the applicable contribution is paid.
- B. **When Coverage of a Spouse, Domestic Partner or Child Terminates.** If you have other than individual coverage, you should notify the Group of any event that affects your coverage, such as: your divorce, termination of a domestic partnership, the death of your spouse or domestic partner, or Medicare eligibility; or a child reaching the age at which coverage terminates or otherwise experiencing an event that would normally result in termination of the child's coverage. The Group will provide you with a form for that purpose. If such change results in you seeking a different type of coverage at a lower rate (such as a switch to individual coverage), the form and requested documentation must be returned within 30 days of the event in order for the change to be effective on the date of the event. If you do not return a completed form and any requested documentation within 30 days of the event, the change in premium will be effective as of the next premium due date after they are received. Nothing in this Subparagraph B is designed to affect the provisions of Section Sixteen governing terminations of coverage. This Subparagraph B only involves the effective date of changes in premium due to terminations of coverage under Section Sixteen.

If you think there are reasons coverage of the person experiencing the change should continue, you must notify the Group of the reasons for the continuation of the coverage, on a form provided to you for that purpose upon your request, together with any requested documentation, no later than 30 days after the date the family member's coverage would usually terminate.

SECTION THREE - MEDICAL NECESSITY AND PRIOR APPROVAL

1. **Care Must Be Medically Necessary.** Coverage will be provided under the Benefit Plan for the covered hospitalization, care, service, technology, test, treatment, drug or supply (collectively, "Service") described in this booklet, as long as the 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 coverage has to be provided for the Service under the Benefit Plan.

The Claims Administrator will decide whether a Service was Medically Necessary. The Claims Administrator will base its decision, in part, on a review of your medical records. The Claims Administrator 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, the Claims Administrator will 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 our attention.

Services will be deemed Medically Necessary only if:

- A. They are clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease;
- 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 generally-accepted standards of medical practice;

- E. They are not primarily for the convenience of you, your family, the Professional Provider or another provider;
 - F. They are not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease; 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 Must Be Approved Standard Treatment.** Except as otherwise required by law, no Service rendered to you will be considered Medically Necessary unless the Claims Administrator determines that the Service 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.** Prior approval is required before you receive certain services covered under this Benefit Plan. The services subject to prior approval are:
- A. Advance imaging such as MRI, MRA, CT, nuclear medicine, nuclear cardiology, PET and other imaging procedures developed from time to time.
 - B. Durable medical equipment with a cost in excess of \$200.
 - C. Home care services.
 - D. Infusion therapy services.
 - E. Inpatient admissions, other than for maternity.
 - F. Organ and tissue transplants (all services).
4. **Prior Approval Procedure.** If you seek coverage for the services listed in paragraph 3 above, you must call the Claims Administrator at 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 6 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. **Your Right to Appeal.** If you or your Professional Provider disagrees with the Claims Administrator's decision, you may appeal by following the procedures set forth in Section Seventeen. Any written appeals must be made to: 165 Court Street, Rochester, NY 14647.
6. **Failure to Seek Approval.** If you fail to seek prior approval for benefits subject to this section, other than with respect to any benefits received due to an Emergency Condition, the Benefit Plan will pay the lesser of (A) \$500 less than what would otherwise have been paid for the care, or (B) 50% of the amount that would otherwise have been paid for the care. You must pay the remaining charges. 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.

SECTION FOUR - COST-SHARING EXPENSES

- Deductible.** Except where stated otherwise, you must pay the first \$250 of Allowable Expenses incurred for In-Network services and \$750 of Allowable Expenses incurred for Out-of-Network services covered under the Benefit Plan during each Calendar Year. If you have other than individual 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 \$750 of Allowable Expenses for In-Network services and \$2,250 of Allowable Expenses for Out-of-Network services covered under the Benefit Plan in a Calendar Year, no further Deductible will be required for any person covered under the Benefit Plan for that Calendar Year. You must also pay a separate \$50 Deductible for each person covered under the Benefit Plan for In-Network and Out-of-Network home care services covered under the Benefit Plan during each Calendar Year. The home care Deductible applies to each Member covered under the Benefit Plan and does not count toward satisfaction of the individual \$250 (In-Network)/\$750 (Out-of-Network) Deductible or the overall \$750 (In-Network)/\$2,250 (Out-of-Network) Deductible.
- Coinsurance.** Except where stated otherwise, after you have satisfied the annual Deductible described above, you will be responsible for a percentage of the Allowable Expense for many Out-of-Network services under the Benefit Plan, which is your Coinsurance. Your Coinsurance for Out-of-Network Benefits is 30%, unless otherwise noted in the section where the service is described.
- Copayments.** You must pay a Copayment for many covered In-Network services at the time services are rendered. Except where stated otherwise, the In-Network Copayment under this Benefit Plan is \$20 for a primary care physician and \$40 for a specialist.
- Additional Payments for Out-of-Network Benefits.** When you receive covered services from an Out-of-Network Provider, in addition to the Coinsurance and the annual Deductible described above, 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 your Deductible and Coinsurance may be less than the provider's actual charge.

When you receive covered services from an Out-of-Network Provider, the Claims Administrator 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 Claims Administrator 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 Claims Administrator will make one inclusive payment in that case, rather than a separate payment for each billed code. Another example of when the payment rules will be applied 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 Claims Administrator receives a claim that does not have the correct modifier, the Claims Administrator 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.

5. **Maximum Deductible, Copayment and Coinsurance Amounts.** When you have expended \$6,350 for services received from In-Network Providers for Deductibles (including the home care Deductible), Coinsurance and Copayments or \$1,750 for services received from Out-of-Network Providers for Deductibles (including the home care Deductible), Coinsurance and Copayments in a Calendar Year, the Benefit Plan will provide coverage for 100% of the Allowable Expense for covered services for the remainder of the Calendar Year. If other than individual coverage applies, when members of the same family covered under the Benefit Plan have paid an aggregate of \$12,700 for Deductibles (including the home care Deductible), Coinsurance and Copayments for services received from In-Network Providers; or \$5,250 for Deductibles (including the home care Deductible) and Coinsurance for services received from Out-of-Network Providers in a Calendar Year, the Benefit Plan will provide coverage for 100% of the Allowable Expense for covered services for the remainder of the Calendar Year. Any charges of an Out-of-Network Provider that are in excess of the Allowable Expense will remain your responsibility.

SECTION FIVE - INPATIENT CARE

1. **In a Facility.** If you are a registered bed patient in a Facility, benefits will be provided under the Benefit Plan 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 the Claims Administrator determines that it is Medically Necessary for you to occupy a private room or the Facility has no semi-private rooms. If you occupy a private room in a Facility, and the Claims Administrator determines that a private room is not Medically Necessary and that the Facility has semi-private rooms, 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. Medications, supplies and equipment that you take home from the Facility;
 - E. Custodial care (see Section Thirteen, paragraph 7); or
 - F. Radio, telephone and television expenses, or beauty and barber services.
3. **Conditions for Inpatient Care; Limitation 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 or surgical care and are not admitted to the hospital for mental health care or for diagnosis and treatment of chemical dependence and/or abuse. The Benefit Plan will provide coverage for any day on which it is Medically Necessary for you to receive inpatient care, subject to the limitation on the number of days of care described in Subparagraph F below.
 - B. **Mental Health Care.** The Benefit Plan will provide coverage for diagnosis and "active treatment" of Mental Illnesses in a Facility that is a hospital as defined by subdivision ten of section 1.03 of the New York Mental Hygiene Law. A hospital does not include a: residential treatment program; group home; school;

camp; halfway house; or other supportive housing. The term “active treatment” means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meets standards prescribed pursuant to the regulations of the Commissioner of Mental Health.

The Benefit Plan will also provide coverage for care in a licensed partial hospitalization program. A partial hospitalization program is an ambulatory treatment program that provides a medically supervised alternative to inpatient treatment.

C. **Inpatient Detoxification.** The Benefit Plan will provide coverage for active treatment for detoxification needed because of chemical dependence. This coverage is available only for services rendered in and billed by:

- (1) A Facility in New York State which is certified by the Office of Alcoholism and Substance Abuse Services;
- (2) A program that the Claims Administrator recognizes as a chemical dependence and abuse treatment program; or
- (3) A Facility in another state that the Claims Administrator recognizes is approved by JCAHO as an alcoholism or chemical dependence and abuse treatment program and meets the appropriate state licensing. If a government hospital meets these criteria, services rendered there will be covered unless no charge would have been made in the absence of coverage under the Benefit Plan.

D. **Inpatient Chemical Dependence and Abuse Rehabilitation.** The Benefit Plan will provide coverage for rehabilitation of chemical dependence and abuse. The Benefit Plan will provide covered services for a 24-hour live-in program of services in a Facility that is a provider for the active rehabilitation and treatment of chemical abuse approved by the Claims Administrator. The program is non-medical and provides rehabilitation and treatment for chemical abuse or dependence in a controlled environment. .

E. **Skilled Nursing Facility.** The Benefit Plan will provide coverage for care in a Skilled Nursing Facility if it is determined that hospitalization would otherwise be Medically Necessary for the care of your condition, illness or injury for up to 45 days in a Year.

In-Network Benefits and Out-of-Network Benefits for a Skilled Nursing Facility will all be counted toward the 45-day per year limit described above.

F. **Physical Rehabilitation.** The Benefit Plan will provide coverage for comprehensive physical medicine and rehabilitation (chemical dependence and abuse programs are excluded) for up to 60 days per Calendar Year for a condition

that in the judgment of your Professional 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 for physical rehabilitation will all be counted toward the 60-day limited described above.

4. **Maternity Care.** The Benefit Plan will provide coverage for inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, even if you do not add the newborn to your coverage or extend your coverage to include the newborn as described in Section Two, paragraph 2 of this booklet, 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 the Claims Administrator determines are 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.
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. **Infertility Treatment Services.** The Benefit Plan will provide coverage for Medically Necessary inpatient Hospital care in connection with infertility treatment services provided by a Professional Provider pursuant to Section Nine, paragraph 20.
7. **Internal Prosthetic Devices.** The Benefit Plan's coverage for inpatient Hospital care includes coverage for internal prostheses that are surgically implanted and Medically Necessary for anatomical repair or reconstructive purposes. Internal prosthetic devices are designed to replace all or part of a permanently inoperative, absent or malfunctioning body organ. Examples of internal prosthetic devices include: cardiac pacemakers, implanted cataract lenses and surgically implanted hardware necessary for joint repair or reconstruction.
8. **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.

9. **End of Life Care.** The Benefit Plan will provide coverage for acute care services at a Facility licensed pursuant to Article 28 of the Public Health Law that specializes in the treatment of terminally ill patients when you are diagnosed with advanced cancer and have fewer than 60 days to live. The Benefit Plan will cover your care when your attending physician, in consultation with the medical director of the Facility, determines that your care would appropriately be provided by the Facility.
10. **Benefits for Inpatient Care.**

In-Network. In-Network Benefits are subject to a \$250 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% 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 the Claims Administrator determines that it was Medically Necessary to use the Facility to perform the surgery.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

2. **Pre-Admission Testing.** The Benefit Plan will provide coverage for tests ordered by a physician which 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 seven days after the tests are given.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

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

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

4. **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, after Deductible.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

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

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

6. **Chemotherapy.** The Benefit Plan will provide coverage for chemotherapy.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

7. **Dialysis.** The Benefit Plan will provide coverage for dialysis treatments of an acute or chronic kidney ailment.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

8. **Mammography Screenings.** The Benefit Plan will provide coverage for mammography screenings for breast cancer according to the Claims Administrator's preventive care guidelines. The screenings may be provided in the outpatient department of a Facility under this section or in a Professional Provider's office pursuant to Section Nine, paragraph 13. At a minimum, the Benefit Plan's coverage for routine mammography screenings under this section and Section Nine, paragraph 13 will be as follows:

- A. **Women at Risk.** The Benefit Plan will provide coverage for mammograms for women of any age who have a prior history of breast cancer or who have a first

degree relative (such as a child, mother or sister) or a paternal or maternal grandmother who has a prior history of breast cancer, if the mammogram is recommended by a physician.

- B. **Women 35 through 39 Years of Age.** The Benefit Plan will provide coverage for one baseline mammogram for women 35 through 39 years of age.
- C. **Women 40 Years of Age and Older.** The Benefit Plan will provide coverage for one mammogram in each Calendar Year for women 40 years of age and older.

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

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

- 9. **Cervical Cytology Screenings (Pap Smears).** The Benefit Plan will provide coverage for screening for cervical cancer and its precursor states for women 18 years of age or older, or for younger women who are sexually active, according to the Claims Administrator's preventive care guidelines. The screening may be provided in the outpatient department of a Facility under this section or in a Professional Provider's office pursuant to Section Nine, paragraph 14. At a minimum, the Benefit Plan will provide coverage for one screening each Calendar Year for women age 18 and older under this section and Section Nine, paragraph 14. 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. In-Network Benefits are covered at 100% of the Allowable Expense.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

- 10. **Mental Health Care.** The Benefit Plan will provide benefits for diagnosis and treatment of Mental Illnesses in a facility that: has an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; or is operated by the Office of Mental Health. A school or camp is not a covered facility for purposes of this paragraph.

In-Network. In-Network Benefits are subject to a \$40 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

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

The Benefit Plan will also provide coverage for visits for family therapy. Family therapy consists of visits that include members of your family in order for your family to understand the illness of another family member and play a meaningful role in the family member's recovery. The Benefit Plan's coverage of a family visit will be the same regardless of the number of family members who attend the family visit. The family therapy visits may only be used by people who are covered under the Benefit Plan.

In-Network. In-Network Benefits are subject to a \$40 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

12. **Covered Therapies.** The Benefit Plan will provide coverage for up to an aggregate of 45 visits per Member per Calendar Year for related rehabilitative physical therapy and physical, occupational, and speech therapy when services are rendered by a licensed physical therapist, occupational therapist or speech language pathologist or audiologist, or by another Facility employee who is licensed to provide such services, and when the Claims Administrator determines that your condition is subject to significant clinical improvement through relatively short-term therapy.

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

Services provided in a Professional Provider's office pursuant to Section Nine, paragraph 2 and in the outpatient department of a Facility pursuant to this section are subject to the visit limit above.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

13. **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.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

14. **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.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% 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 or licensed home care services agency if your Professional Provider and the Medical Director determine that the visits are Medically Necessary.

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

2. **Eligibility for Home Care.** The Benefit Plan will provide coverage for home care only if all the following conditions are met:

- A. A treatment plan is established and approved in writing by your Professional Provider;
- B. You apply to the home care provider through your Professional Provider with supporting evidence of your need and eligibility for the care; and
- C. The home care is related to an illness or injury for which you were hospitalized or for which you would have been hospitalized or confined in a nursing facility. The 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 the Claims Administrator determines that you no longer need such services.

3. **Home Care Services Covered.** Home 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, that consist primarily of direct care rendered to you;
 - C. Physical, occupational or speech therapy provided by the home health agency or home care services agency; and
 - D. Medical supplies, drugs and medications prescribed by your physician, laboratory services, durable medical equipment and infusion therapy, when provided by or on behalf of the home health agency or home care services agency, but only to the extent such items would have been covered under the Benefit Plan if you were a patient 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 Treatment Plan.** If you fail or are unable to comply with the home care treatment plan, the Benefit Plan will terminate benefits for that plan of care.
5. **Number of Visits.** The Benefit Plan will cover up to 180 home care visits in a Calendar Year. In-Network and Out-of-Network Benefits will both be counted toward the 180-visit limit.
6. **Benefits for Home Care.**

In-Network. In-Network Benefits are covered at 100% of the Allowable Expense, after a \$50 Deductible.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after a \$50 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.
 - 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 that 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. The services 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. 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.

D. Medical care provided by a physician.

- 4. **Number of Days.** The Benefit Plan will provide coverage for hospice care, beginning with the first day on which care is provided. Each day you receive care from or through the hospice counts as a day of hospice care. The Benefit Plan will also provide coverage for up to five visits for bereavement counseling services to your family, either before or after your death.
- 5. **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 under this booklet, the Benefit Plan will not provide additional coverage under this booklet for any services related to your terminal illness that have been or should be included in the Claims Administrator's payment to the hospice program for the care you receive. However, should you require services covered by the Benefit Plan for a condition not covered under the hospice program, coverage will be available under this Benefit Plan for those covered services.
- 6. **Benefits for Hospice Care.**

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

Out-of-Network. Out-of-Network Benefits are covered at 70% 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. **Surgery.** Surgery includes operative procedures for the treatment of disease or injury and for elective termination of pregnancy. It includes any pre 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. Surgery 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 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, after Deductible.

Out-of-Network. Out-of-Network Benefits are covered at 70% 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, after Deductible.

Out-of-Network. Out-of-Network Benefits are covered at 70% 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, after Deductible.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

- D. **Multiple Surgical Procedure Rules.** If multiple surgical procedures are performed during the same operative session, the following rules apply. In these rules, the term “primary procedure” means the most expensive procedure, i.e., the procedure with the highest Allowable Expense. The term “secondary procedure” means any procedure other than the primary procedure.

A laparoscopic procedure with multiple entry points is considered to be a single incision for purposes of applying these rules.

- (1) **Through the Same Incision.** If covered multiple surgical procedures are through the same incision, the Benefit Plan will provide the benefits described above for the primary procedure. The Claims Administrator will pay 50% of the amount otherwise payable under this Benefit Plan for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions.

The Claims Administrator will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure. Examples of incidental procedures are: an appendectomy; lysis of adhesions; splenectomy without separate pathology; biopsies of lymph nodes, liver, omentum or other organs; hernia through the same incision (umbilical, ventral, internal inguinal); secondary organs and en bloc incisions; tube enterostomies for decompression; and vasectomy accompanying prostatectomy.

- (2) **Through Different Incisions.** If covered multiple surgical procedures are performed during the same operative session but through different incisions, the Benefit Plan will provide the following benefits:
- (a) The benefit described above for the primary procedure; plus
 - (b) 50% of the amount otherwise payable for all other procedures.

2. **Covered Therapies.** The Benefit Plan will provide coverage for up to an aggregate of 45 visits per Member per Calendar Year for related rehabilitative physical therapy and physical, occupational, and speech therapy when services are rendered by a licensed physical therapist, occupational therapist or speech language pathologist or audiologist, or by another Professional Provider licensed to provide such services, and when the Claims Administrator determines that your condition is subject to significant clinical improvement through relatively short-term therapy.

Services provided in the outpatient department of a Facility pursuant to Section Six, paragraph 12 and in a Professional Provider’s office pursuant to this section are subject to the visit limit above.

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

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

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

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

4. **Additional Surgical Opinions.** The Benefit Plan will provide coverage for a second opinion, or a third opinion if the first two opinions do not agree, with respect to proposed surgery subject to all the following conditions:

- A. You seek the second or third surgical opinion after your surgeon determines your need for surgery.
- B. The second or third surgical opinion is rendered by a physician:
 - (1) Who is a board certified specialist; and
 - (2) Who, by reason of his or her specialty, is an appropriate physician to consider the proposed surgical procedure.
- C. The second or third surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under the Benefit Plan if such surgery was performed.
- D. You are examined in person by the physician rendering the second or third surgical opinion.
- E. The specialist who renders the opinion does not also perform the surgery.

In-Network. In-Network Benefits are subject to a \$20 Copayment for a primary care physician and a \$40 Copayment for a specialist.

Out-of-Network. Out-of-Network Benefits are covered at 70% 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 are subject to a \$20 Copayment for a primary care physician and a \$40 Copayment for a specialist.

Out-of-Network. Out-of-Network Benefits are covered at 70% 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, practicing consistent with section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed under the New York Public Health Law or comparable law of another state.

In-Network. In-Network Benefits are covered at 100% of the Allowable Expense, after Deductible. For maternity care that is considered preventive in accordance with the preventive services provision of the Benefit Plan (Section Ten, paragraph 2) In-Network Benefits are covered at 100% of the Allowable Expense.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

- B. **Complications of Pregnancy and Termination.** The Benefit Plan will provide coverage for complications of pregnancy and for terminations resulting from the complications.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

- C. **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 70% of the Allowable Expense, after Deductible.

7. **Inpatient Medical Services.** The Benefit Plan will provide coverage for medical visits by a Professional Provider on any day of inpatient care covered under Section Five, or for up to 120 days in a “single confinement”. 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 are covered at 100% of the Allowable Expense, after Deductible.

Out-of-Network. Out-of-Network Benefits are covered at 70% 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 one adult routine physical examination per Member, per Calendar Year.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

- (2) **Well Child Visits and Immunizations.** The Benefit Plan will provide coverage for well child visits in accordance with the schedule recommended by the American Academy of Pediatrics. The Benefit Plan will also cover childhood immunizations recommended by the Advisory Committee on Immunization Practices (“ACIP”), in accordance with the ACIP 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 100% of the Allowable Expense.

- (3) **Adult Immunizations.** The Benefit Plan will provide coverage for adult immunizations according to ACIP recommendations.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% 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, after Deductible.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

(2) **Vision Examinations.** Benefits will be provided for routine and diagnostic vision examinations as follows:

(a) **Routine Vision Examinations.** Routine vision examinations are limited to one exam per Calendar Year subject to the following:

In-Network. In-Network Benefits are subject to a \$40 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

(b) **Diagnostic Vision Examinations.** Diagnostic vision examinations are covered, subject to the following:

In-Network. In-Network Benefits are subject to a \$40 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

(3) **Hearing Examinations.** Benefits will be provided for diagnostic hearing examinations as follows:

In-Network. In-Network Benefits are subject to a \$40 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

(4) **Acupuncture.** Benefits will be provided for acupuncture services. Services must be rendered by a Professional Provider licensed to provide such services; and determined by our Medical Director to be Medically Necessary.

Acupuncture services are limited to a maximum of 10 visits per Member, per Year. In-Network Benefits and Out-of-Network Benefits will both be counted toward the annual visit maximum.

In-Network. In-Network Benefits are covered at 50% of the Allowable Expense.

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

- C. **Diagnostic and/or Treatment Office Visits.** The Benefit Plan will provide coverage for office visits to diagnose and/or treat illness or injury.

In-Network. In-Network Benefits are subject to a \$20 Copayment for a primary care physician or \$40 Copayment for a specialist.

Out-of-Network. Out-of-Network Benefits are covered at 70% 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 are subject to a \$20 Copayment for a primary care physician or \$40 Copayment for a specialist.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

9. **Imaging Examinations and Radioactive Isotope Procedures.** Subject to the provisions below, the Benefit Plan will provide coverage for the professional component of the following procedures, when rendered and billed by a Professional Provider: x-ray examinations; radioactive isotope; ultrasound; computerized axial tomography (“CAT”) scan; positron emission tomography (“PET”) scan; and magnetic resonance imaging (“MRI”). The Benefit Plan will provide coverage for diagnostic and routine procedures. Prior approval is required for CAT, MRI, and MRA procedures as described in Section Three.

The Benefit Plan will provide coverage for a CAT or PET 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 or PET scan or other procedure has been approved by law. If the CAT or PET scan or other procedure is performed in New York State, the installation of the equipment must have been approved under the New York 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 or PET scan or other procedure is performed in a Professional Provider's office, the Benefit Plan will provide benefits for the CAT or PET scan or other procedure only if the New York Public Health Law provides an approval procedure for such a location and only if the installation of the equipment where you receive the service has been approved under that procedure.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

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

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

11. **Chemotherapy.** The Benefit Plan will provide coverage for chemotherapy.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

12. **Dialysis.** The Benefit Plan will provide coverage for dialysis treatments of an acute or chronic kidney ailment.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

13. **Mammography Screenings.** The Benefit Plan will provide coverage for mammography screenings for breast cancer according to the Claims Administrator's preventive care guidelines. The screenings may be provided in a Professional Provider's office under this section or in the outpatient department of a Facility pursuant to Section Six, paragraph 8. At a minimum, the coverage for routine mammography screenings under this section and Section Six, paragraph 8 will be as follows:

- A. **Women at Risk.** The Benefit Plan will provide coverage for mammograms for women of any age who have a prior history of breast cancer or who have a first degree relative (such as a child, mother or sister) or a maternal or paternal grandmother who has a prior history of breast cancer, if the mammogram is recommended by a physician.

- B. **Women 35 through 39 Years of Age.** The Benefit Plan will provide coverage for one baseline mammogram for women 35 through 39 years of age.
- C. **Women 40 Years of Age and Older.** The Benefit Plan will provide coverage for one mammogram in each Calendar Year for women 40 years of age and older.

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

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

14. **Gynecological Services.** The Benefit Plan will provide coverage for gynecology visits, including coverage for screening for cervical cancer and its precursor states for women 18 years of age and older, or for younger women who are sexually active, according to the Claims Administrator's preventive care guidelines. The screening may be provided in the outpatient department of a Facility pursuant to Section Six, paragraph 9 or in a Professional Provider's office pursuant to this section. At a minimum, the Benefit Plan will provide coverage for one screening each Calendar Year for women age 18 and older under this section and Section Six, paragraph 9. 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. In-Network Benefits for routine visits are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic visits are subject to a \$20 Copayment for a primary care physician or a \$40 Copayment for a specialist.

Out-of-Network. Out-of-Network Benefits for routine and diagnostic visits are covered at 70% of the Allowable Expense, after Deductible.

15. **Screenings for Prostate Cancer.** The Benefit Plan will provide coverage for diagnostic screenings for prostate cancer, including standard diagnostic testing and standard diagnostic exams, according to the Claims Administrator's preventive care guidelines. At a minimum, the Benefit Plan will provide coverage for prostate screenings as follows:
- A. **Men with a Prior History of Prostate Cancer.** The Benefit Plan will provide coverage for standard diagnostic testing for men of any age who have had a prior history of prostate cancer.

- B. **Men at Risk.** The Benefit Plan will provide coverage for one standard diagnostic exam in each Calendar Year for men over the age of 40 who have a family history of prostate cancer or who have other risk factors for prostate cancer.
- C. **Men 50 Years of Age or Older.** The Benefit Plan will provide coverage for one standard diagnostic exam in each Calendar Year for men 50 years of age and older.

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

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

- 16. **Allergy Testing and Treatment.** The Benefit Plan will provide coverage for allergy testing and treatment, including test and treatment materials. Allergy testing includes injections and scratch and prick tests to determine the nature of allergies. Allergy treatment includes desensitization treatments (injections) to alleviate allergies, including allergens.

In-Network. In-Network Benefits are subject to a \$20 Copayment for a primary care physician or a \$40 Copayment for a specialist.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

- 17. **Mental Health Care.** The Benefit Plan will provide benefits for diagnosis and treatment of Mental Illnesses provided by a: psychiatrist or psychologist licensed to practice in this state; licensed clinical social worker who meets the requirements of section 4303 (n) of the New York Insurance Law; or professional corporation or university faculty practice corporation of the psychiatrist, psychologist or social worker.

In-Network. In-Network Benefits are subject to a \$40 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

- 18. **Chiropractic Care.** The Benefit Plan will provide coverage for 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. In-Network Benefits are subject to a \$40 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

19. **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 covered at 100% of the Allowable Expense.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

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

- A. **Infertility Defined.** For purposes of this paragraph, infertility is determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine. In general, infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse. Earlier evaluation and treatment may, however, be justified based on medical history and physical findings; and is warranted after six months for women over age 35 years.

- B. **Coverage Provided for Individuals 21 to 44 Years of Age.** The benefits provided by this paragraph are available only to Members covered under this Benefit Plan who are between the ages of 21 and 44 as of the date the services are rendered.
- C. **Coverage Only Provided for Appropriate Candidates.** Coverage under this paragraph will only be provided to “Appropriate Candidates” within the age group described in Subparagraph B. An Appropriate Candidate is an individual determined to be an Appropriate Candidate by the treating physician, in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society of Reproductive Medicine.
- D. **Covered Services.** Subject to the other provisions of this paragraph and this booklet, the Benefit Plan will provide benefits under this paragraph for:
- (1) Medical and surgical procedures, such as artificial insemination, intrauterine insemination, and dilation and curettage (“D & C”), that would correct malformation, disease or dysfunction resulting in infertility; and
 - (2) Services in relation to diagnostic tests and procedures necessary:
 - (a) To determine infertility; or
 - (b) In connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered by this paragraph are:
 - (i) Hysterosalpingogram;
 - (ii) Hysteroscopy;
 - (iii) Endometrial biopsy;
 - (iv) Laparoscopy;
 - (v) Sono-hysteroqram;
 - (vi) Post-coital tests;
 - (vii) Testis biopsy;
 - (viii) Semen analysis;
 - (ix) Blood tests;

- (x) Ultrasound; and
 - (xi) Other Medically Necessary diagnostic tests and procedures, unless otherwise excluded in accordance with the Claims Administrator's administrative guidelines with respect to infertility.
- E. **Plan of Care Required.** All services covered under this paragraph must be prescribed by a physician as part of a "plan of care." The plan of care must be in writing, and must be available for review by the Claims Administrator. Services or procedures that are inconsistent with or not included in the plan of care will not be covered.
- F. **Services Must Be Received from Eligible Providers.** Services covered under this paragraph must be received from "Eligible Providers" as according to the Claims Administrator's administrative guidelines. In general, an Eligible Provider is defined as a health care provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine for the performance of procedures and treatments for the diagnosis and treatment of infertility.
- G. **Excluded Services.** The Benefit Plan will not pay benefits for the following reproductive procedures or services:
 - (1) In-Vitro Fertilization;
 - (2) Gamete Intra-Fallopian Transfer (GIFT);
 - (3) Zygote Intra-Fallopian Transfer (ZIFT);
 - (4) Reversal of elective sterilizations, including vasectomies and tubal ligations;
 - (5) Sex change procedures;
 - (6) Cloning;
 - (7) Sperm banking and donor fees associated with artificial insemination or other procedures;
 - (8) Other procedures or categories of procedures excluded by the Claims Administrator in accordance with its administrative guidelines. For questions as to whether or

not a particular reproductive procedure or service is excluded, please contact the Claims Administrator.

H. **Experimental Procedures Not Covered.** This paragraph does not cover services or procedures that the Claims Administrator determines to be experimental, according to standards and guidelines that are no less favorable than those established and adopted by the American Society for Reproductive Medicine and the American College of Obstetricians and Gynecologists (“ACOG”).

I. **Deductibles, Coinsurance and Copayments.** The benefits of this paragraph are subject to any applicable Deductible, Coinsurance or Copayment provisions under this section for similar services. For example, any Deductible or Coinsurance for surgery under Paragraph 1 will also apply to surgery under this paragraph; any Deductible 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 or Coinsurance for x-ray and imaging procedures under Paragraph 9 will also apply to x-ray and imaging procedures under this paragraph.

21. **Bone Density Testing.** The Benefit Plan will cover bone mineral density measurements and tests for the detection of osteoporosis. The Claims Administrator will apply its 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, of 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.

In-Network. In-Network Benefits are subject to a \$40 Copayment. For any bone mineral density measurement or test provided in accordance with the preventive services provision of the Benefit Plan (Section Ten, paragraph 2) In-Network

Benefits are covered at 100% of the Allowable Expense.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

22. **Mastectomy Care.** In addition to the surgical services covered under paragraph 1 above, the Benefit Plan will also provide coverage for prostheses and treatment of physical complications of a mastectomy, including lymphedemas. The Benefit Plan's coverage includes benefits for mastectomy bras.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

SECTION TEN - ADDITIONAL BENEFITS

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

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

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

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

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

Applied behavior analysis services are limited to 680 hours per Member per Calendar Year. In-Network Benefits and Out-of-Network Benefits will both be counted toward this 680 hour limit.

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

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

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

- 2. **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. Insulin and oral agents for controlling blood sugar (limited to a 30-day supply when purchased at a retail pharmacy, or a 90-day supply when purchased at a mail order pharmacy);
- B. Blood glucose monitors;
- C. Blood glucose monitors for the visually impaired;
- D. Data management systems;
- E. Test strips for glucose monitors, visual reading and urine testing;
- F. Injection aids;
- G. Cartridges for the visually impaired;
- H. Insulin pumps and appurtenances thereto;
- I. Insulin infusion devices; and
- J. 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 and supplies are covered when made necessary by normal wear and tear. Repair and replacement of diabetic equipment and supplies made necessary because of loss or damage caused by misuse or mistreatment are not covered.

The 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.

Prior Authorization. Certain drugs, supplies and equipment prescribed for treatment of diabetes are subject to prior authorization. Please see Section Three, paragraph 3 for the prior authorization procedures.

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 In-Network 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.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

2. **Preventive Services Required by the Federal Patient Protection and Affordable Care Act.** The Benefit Plan 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 Claims Administrator’s website at www.excellusbcb.com, or will be mailed to you upon request. You may request the list by calling the Claims Administrator.

In-Network. 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. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

3. **Durable Medical Equipment; External Prosthetic Devices; Orthotic Devices; Medical Supplies.**

- A. **Durable Medical Equipment.** The Benefit Plan will provide coverage for the rental, purchase, repair or maintenance of durable medical equipment and for supplies and accessories necessary for the proper functioning of the equipment. The Benefit Plan will provide coverage for durable medical equipment that your physician or other licensed/authorized provider and the Medical Director determines 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. The Claims Administrator will determine whether the item should be purchased or rented.

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

No coverage is provided for the cost of rental, purchase, repair or maintenance of durable medical equipment covered under warranty or the cost of rental, purchase, repair or maintenance due to misuse, loss, natural disaster or theft, unless approved in advance by the Medical Director. No coverage is provided for the additional cost of deluxe equipment that is not Medically Necessary. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary. The Benefit Plan will not provide coverage for delivery or service charges, or for routine maintenance.

- B. **External Prosthetic Devices.** The Benefit Plan will provide coverage for external prosthetic devices necessary to relieve or correct a condition caused by an injury or illness. The Benefit Plan will cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a

replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Your physician must order the prosthetic device for your condition before its purchase. Although the Claims Administrator requires that a physician prescribe the device, this does not mean that the Claims Administrator will automatically determine you need it. The Claims Administrator will determine if the prosthetic device is Medically Necessary. The Benefit Plan will only provide benefits for a prosthetic device that the Claims Administrator determines 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. External prosthetic devices include, for example, the following that are used to replace functioning natural body parts: artificial arms, legs, and eyes; ostomy bags and supplies required for their use; and catheters. Prosthetic devices do not include, for example: hearing aids; eyeglasses; contact lenses; medical supplies; wigs; or foot orthotics such as arch supports or insoles, regardless of the Medical Necessity of those items. Dentures or other devices used in connection with the teeth are also not covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

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 unless approved in advance by the Medical Director. No coverage is provided for the additional cost of a deluxe device that is not Medically Necessary. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary. The Benefit Plan will not provide coverage for delivery or service charges, or for routine maintenance related to prosthetic devices.

- C. **Orthotic Devices.** The Benefit Plan will provide coverage for orthotic devices that are rigid or semi-rigid (having molded plastic or metal stays) 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. The Benefit Plan will cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Orthotic devices include orthopedic braces and custom-built supports. Your physician must order the orthotic device for your condition before its purchase. Although the Claims Administrator requires that a physician prescribe the device, this does not mean that the Claims Administrator will automatically determine you need it. The Claims Administrator will determine if the orthotic device is Medically Necessary. The Benefit Plan will only provide benefits for an orthotic device that the Claims Administrator determines can adequately meet the needs of your condition at the least cost. You are

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

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

- D. **Medical Supplies.** The Benefit Plan will provide coverage for disposable medical supplies when you are not an inpatient in a Facility and the Claims Administrator determines that a large quantity is necessary for the treatment of conditions such as cancer, diabetic ulcers, surgical wounds and burns. Disposable medical supplies: are used to treat conditions caused by injury or illness; do not withstand repeated use (cannot be used by more than one patient); and are discarded when their usefulness is exhausted. Examples of disposable medical supplies include: bandages; surgical gloves; tracheotomy supplies; and compression stockings. Your physician must order these supplies.

Not included in this benefit are: supplies that the Claims Administrator considers to be purchased primarily for comfort or convenience; delivery and/or handling charges.

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

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

4. **Pre-hospital Emergency Services and Transportation.** The Benefit Plan will provide coverage for services to evaluate and treat an Emergency Condition when such services are provided by an ambulance service certified under the Public Health Law. The Benefit Plan will also provide coverage for land or air 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 (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;
 - 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 \$40 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

5. **Ambulance Service.** In addition to the services described in paragraph 4 above, the Benefit Plan will also provide coverage for the following Medically Necessary services provided by a certified ambulance service:
- A. Ground or air ambulance service for an urgent condition. When you have an urgent condition, the need for care is less than the need for care of an Emergency Condition, but the condition requires immediate attention. An urgent condition is one that may become an Emergency Condition in the absence of treatment.
 - B. Ground or air transportation between Facilities.

In-Network. In-Network Benefits are subject to a \$40 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

6. **Care in a Freestanding Urgent Care Center.** The Benefit Plan will provide coverage for care at a freestanding urgent care center to treat your illness or condition. The Benefit Plan will provide coverage for medical visits of Professional Providers who are not employees or interns of the urgent care center.

In-Network. In-Network Benefits are subject to a \$40 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

7. **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 Member'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. For example, any Deductible 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 or Coinsurance for x-ray and imaging procedures under Section Nine, paragraph 9 will also apply to x-ray and imaging procedures under this paragraph.

8. **Individual Case Management.**

- A. **Alternative Benefits.** If you agree to participate and abide by the policies of the Benefit Plan and the Claims Administrator, in addition to benefits specified in this booklet, you may be provided, outside the terms of the Benefit Plan, benefits for services, for up to a 60-day period, furnished by any In-Network Provider pursuant to the alternative treatment plan of the Claims Administrator for a Member whose condition would otherwise require hospitalization.

The Benefit Plan may provide such alternative benefits if and only for so long as the Claims Administrator 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 the 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 its expressed terms.

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 of the Benefit Plan. Upon such application for renewal, the Claims Administrator will review the Member's condition and may agree to a renewal of

such alternative benefits and services. Renewals must be in writing and the Claims Administrator's determination will be final.

The alternative benefits you receive will be in lieu of the benefits the Benefit Plan would normally provide to you under this booklet for the treatment of your condition. As a result, the Benefit Plan may require you to agree to waive certain benefits in order to receive the alternative benefits agreed upon. You may return to utilization of benefits at any time upon prior written notice to the Claims Administrator. However, the benefits remaining available to you will be reduced in a manner that appropriately reflects the alternative benefits you used.

- B. Appeals of Individual Case Management.** If the Claims Administrator 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 the Claims Administrator's Member Services Department at the phone number located on your identification card.

SECTION ELEVEN - EMERGENCY CARE

1. **Eligibility for Benefits.** The Benefit Plan will provide coverage for Emergency Services provided by an In-Network Provider or Out-of-Network Provider. The Benefit Plan will also provide coverage for medical visits of Professional Providers to treat an Emergency Condition in an emergency room; except, however, that the Benefit Plan will not provide coverage for Facility employees or interns.

When you make visits to the emergency room for a condition that is not an Emergency Condition, 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.

2. **Payment for Emergency Services.**

In-Network. In-Network Benefits are subject to a \$50 Copayment.

Out-of-Network. Out-of-Network Benefits are subject to a \$50 Copayment.

3. **Payment for a Professional Provider's Hospital Emergency Room Visit.**

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 STEM CELL (BONE MARROW) TRANSPLANTS

The Benefit Plan will provide coverage for all of the benefits otherwise covered under this booklet for solid organ and stem cell (from bone marrow peripheral or umbilical cord blood) transplants subject to the following limits:

1. **Care in Approved Transplant Centers.** Certain types of organ transplant procedures must be performed in transplant centers certified or otherwise approved by the appropriate regulatory authority for the specific type of transplant procedure being performed. The types of organ transplants that must be performed in certified transplant centers are: bone marrow; liver; heart; lung; heart-lung; kidney; and kidney-pancreas. You may contact the Claims Administrator if you wish to obtain a list of certified transplant centers.
2. **No Coverage of Experimental or Investigational Organ Transplants.** The Benefit Plan will not provide coverage for any benefits for organ transplants the Claims Administrator determines to be experimental or investigational. The Claims Administrator maintains and revises from time to time a list of organ transplant procedures that it determines not to be experimental or investigational and that, therefore, are covered under this Benefit Plan. You may contact the Claims Administrator if you have a question concerning whether a particular transplant procedure is covered.
3. **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 this Benefit Plan when they result from or are directly related to a covered organ or bone marrow transplant.
4. **Coverage for Donor Searches or Screenings.** The Benefit Plan will not provide coverage for costs relating to searches or screenings for donors of organs.
5. **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 – 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. **Blood Products.** The Benefit Plan will not provide coverage for the cost of blood, blood plasma, other blood products, or blood processing or storage charges, when they are available free of charge in the local area, except the Benefit Plan will provide coverage for blood required for the treatment of hemophilia when billed by a Facility. When not free in the local area, the Benefit Plan will cover blood charges, even if you donate or store your own blood, if billed by a Facility, ambulatory surgery center, or a certified blood bank.
2. **Certification Examinations.** The 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.
3. **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 the following: breast 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 will also 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 will also provide coverage for services in connection with reconstructive surgery following a mastectomy, as provided in Section Nine.
4. **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 the Benefit Plan in the absence of a court order;
 - B. The service or care has been pre-authorized by the Benefit Plan, if required; and
 - C. It is determined, in advance, that the service or care is Medically Necessary and covered under the terms of the Benefit Plan.

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

5. **Criminal Behavior.** The 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.
6. **Custodial Care.** The Benefit Plan will not provide coverage for any service or care that is custodial in nature, or any therapy that the Claims Administrator determines is not expected to improve your condition. Care is considered custodial when it is primarily for the purpose of meeting personal needs and includes activities of daily living such as help in transferring, bathing, dressing, eating, toileting, and such other related activities.
7. **Dental Care.** The 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 reasons(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 TMJ disorder, or dental oral surgery. The Benefit Plan will, however, provide the benefits set forth in this booklet for service and care for treatment of sound natural teeth provided within 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. The Benefit Plan will also provide coverage for the services set forth in this booklet that the Claims Administrator determines are Medically Necessary for treatment of a congenital anomaly or disease that was present at birth, such as cleft palate and ectodermal dysplasia. The Benefit Plan will cover institutional provider services for dental care when the Claims Administrator determines there is an underlying medical condition requiring these services.
8. **Developmental Delay.** The Benefit Plan will not provide coverage for educational services related to evaluation, testing and treatment of behavioral disorders, learning disabilities, minimal brain dysfunction, development and learning disorders, or developmental delays. The Benefit Plan will also not provide benefits for any covered service or care set forth in this booklet when rendered in connection with such conditions, unless Medically Necessary.
9. **Disposable Supplies; Hair Prosthetics; 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. Wigs, hair prosthetics, or hair implants;
 - C. 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.
10. **Reversal of Elective Sterilization.** The Benefit Plan will not provide coverage for any service or care related to the reversal of elective sterilization.
11. **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 the Claims Administrator determines that the Service is experimental or investigational.

"Experimental or investigational" means that the Claims Administrator determines 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, the Claims Administrator may, in its discretion, require that any or all of the following five criteria be met:

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

This exclusion will not apply to Qualified Clinical Trial expenses and shall not limit in any way benefits available for prescription drugs otherwise covered under the 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 the Claims Administrator's guidelines.

- 12. **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 the 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; the Claims Administrator will presume that the service or care would have been furnished without charge. You must prove to the Claims Administrator that a service or care would not have been furnished without charge.

13. **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 (VA); 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 the Claims Administrator determines that emergency care is Medically Necessary and it is not possible for you to be transferred to another Facility.

14. **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 its benefits by the amount Medicare would have paid for the services. 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 its 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 the Benefit Plan provides benefits.
15. **Hypnosis/Biofeedback.** The Benefit Plan will not provide coverage for hypnosis or biofeedback.
16. **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 (VA) has the responsibility to provide the service or care.
17. **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. The Benefit Plan will provide benefits for services covered under this booklet 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 booklet, 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 you received payment for under the mandatory automobile no-fault coverage.
18. **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 booklet; even when an In-Network Provider considers the service or care to be Medically Necessary and appropriate.
19. **Nutritional Therapy.** The Benefit Plan will not provide coverage for any service or care related to nutritional therapy, unless the Claims Administrator determines that it is Medically Necessary or that it qualifies as diabetes self-management education. The Benefit Plan will not provide coverage for commercial weight loss programs or other programs with dietary supplements.
20. **Prescription Drugs.** The Benefit Plan will not provide coverage for service or care related to prescription drugs, over-the-counter (nonprescription) drugs, or injections, except for: prescription drugs, and/or injections, that are administered to you in the

course of a covered outpatient or inpatient treatment in a Facility or Professional Provider's office, or through home health care benefits; insulin and oral agents for controlling blood sugar; and contraceptive drugs covered under Section Ten, paragraph 2.

21. **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.
22. **Prohibited Referral.** The Benefit Plan will not provide coverage for any pharmacy, clinical laboratory, radiation therapy, physical therapy, x-ray, or imaging services that were provided pursuant to a referral prohibited by the New York Public Health Law.
23. **Reproductive Procedures.** The Benefit Plan will not provide coverage for the following reproductive procedures or services: in vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cloning, sperm banking and donor fees associated with artificial insemination or other procedures, or other procedures or categories of procedures excluded by the Claims Administrator in accordance with its administrative guidelines. For questions as to whether or not a particular reproductive procedure or category of procedure is excluded, please contact the Claims Administrator.
24. **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, corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, toenails, or symptomatic complaints of the feet. The Benefit Plan will, however, provide coverage for foot orthotics under your benefits for orthotics.
25. **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.
26. **Services Starting Before Coverage Begins.** If you are receiving care on the Effective Date of your coverage under the Benefit Plan, the Benefit Plan will not provide benefits for any service or care you receive:
 - A. Prior to the Effective Date of your coverage under the Benefit Plan; or
 - B. On or after the Effective Date of your coverage under the Benefit Plan, if that service or care is covered under a provision in any other health benefits contract, program, or plan that extends benefits when you are totally disabled on the date coverage under the other contract, program, or plan ends.

27. **Smoking Cessation Programs.** The Benefit Plan will not provide coverage for smoking cessation programs.
28. **Social Counseling and Therapy.** The Benefit Plan will not provide coverage for any service or care related to family, marital, religious, sex, or other social counseling or therapy, except as otherwise provided under this booklet.
29. **Special Charges.** The Benefit Plan will not provide coverage for charges billed to you for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, or completion of claims forms. This exclusion applies to any late charges or extra day charges that you incur upon discharge from a Facility, because you did not leave the Facility before the Facility's discharge time.
30. **Transsexual Surgery and Related Services.** The Benefit Plan will not provide coverage for surgery, or for any other service or care set forth in this booklet that is related to or leads up to such surgery, that is designed to alter the physical characteristics of your biologically determined gender to those of another gender, unless Medically Necessary.
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, or routine hearing examinations and/or visits for the purpose of prescribing, fitting, servicing, or changing hearing aids; and
 - B. 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 loss programs. The Benefit Plan will also not provide benefits for any covered service or care set forth in this booklet when rendered in connection with weight reduction or dietary control, including, but not limited to, laboratory services, and gastric stapling, gastric by-pass, gastric bubble or other surgery for treatment of obesity, unless Medically Necessary.
34. **Workers' Compensation.** The Benefit Plan will not provide coverage for any service or care for which benefits are provided under a workers' compensation or similar law.

SECTION FOURTEEN - WAITING PERIODS

There are no waiting periods for pre-existing conditions under the Benefit Plan.

SECTION FIFTEEN - COORDINATION OF BENEFITS

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

1. **When You Have Other Health Benefits.** It is not unusual to find yourself covered by two health insurance contracts, plans, programs, 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. One plan will pay its full benefit as the primary plan. The other plan will pay secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance plan:
 - A. Any group or blanket insurance contract, plan, program, or policy, including HMO and other prepaid group coverage, except that blanket school accident coverage or such coverage offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;
 - B. Any self-insured or noninsured plan or program, or any other plan or program arranged through any employer, trustee, union, employer organization or employee benefit organization;
 - C. Any Blue Cross, Blue Shield or other service type group plan;
 - D. Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and
 - E. Medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional "fault" type contracts.
2. **Rules to Determine Payment.** In order to determine which plan is primary, certain rules have been established. The first of the rules listed below which applies shall determine which plan shall be primary:
 - A. If the other plan does not have a provision similar to this one, then it will be primary;
 - B. If you are covered under one plan as an employee, subscriber, or primary member and you are only covered as a family member under the other plan, the plan

which covers you as an employee, subscriber, or primary member will be primary; or

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

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

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

- D. If you are covered under one of the plans as an active employee, neither laid-off nor retired, or as the family member of such an active employee, and you are covered as a laid-off or retired employee or a laid-off or retired employee's family member under the other plan, the plan covering you as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.

- E. If none of the above rules determine which plan shall be primary, then the plan that has covered you for the longest time will be primary.

3. **Payment of the Benefit When This Benefit Plan Is Secondary.** When this Benefit Plan is secondary, the benefits of this Benefit Plan 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, the Benefit Plan will not pay more than it would have paid if it were primary.

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 Group and/or the Claims Administrator will request information from that plan so the Claims Administrator can process your claims. If the primary plan does not respond within 30 days, the Claims Administrator may assume that the primary plan's benefits are the same as the Benefit Plan's. If the primary plan sends the information after 30 days, the Benefit Plan will adjust its payment, if necessary.

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

4. **Right to Receive and Release Necessary Information.** The Benefit Plan, the Group and the Claims Administrator have the right to release or obtain information that they believe necessary to carry out the purpose of this section. The Benefit Plan, the Group and the Claims Administrator 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. The Benefit Plan, the Group and the Claims Administrator will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish any information that the Benefit Plan, the Group and the Claims Administrator request. If you do not furnish the information, the Benefit Plan has the right to deny payments.
5. **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 Group and/or the Claims Administrator decide the Benefit Plan should have paid. These payments are the same as benefits paid.
6. **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, it will be necessary for you to refund to the Benefit Plan the amount by which it should have reduced the payment it made. The Benefit Plan also has the right to recover the overpayment from the other health benefits plan if the Benefit Plan has not already received payment from that other plan. You must sign any document that the Group and/or the Claims Administrator deems 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.

1. **Termination of the Benefit Plan.** Your benefits under the Benefit Plan may be terminated at any time if the Group ends the Benefit Plan.
2. **Termination of Your Coverage under This Benefit Plan.** In the following instances, the Benefit Plan will continue in force, but your coverage under the Benefit Plan will be terminated:
 - A. You experience a qualifying event and as a result you choose to terminate your coverage. You must give the Group thirty (30) days' written notice. Your coverage will terminate on the date to which your contributions are paid;
 - B. You are no longer a Member of the Group. Your coverage will terminate on the last day of the month in which your employment terminates or you no longer satisfy the eligibility requirements for the Benefit Plan;
 - C. You make an intentional misrepresentation of a material fact or commit fraud in applying for coverage or in filing a claim under this Benefit Plan. Your coverage will terminate 30 days from the date notice is provided to you;
 - D. On your death or the death of the employee or member of the Group. Your coverage under this Benefit Plan will automatically terminate on the date after your death or the death of the employee or member of the Group;
 - E. Termination of the employee or member of the Group's marriage. If the employee or member of the Group becomes divorced, or the employee or member of the Group's marriage is annulled, coverage of the employee or member of the Group's spouse under this Benefit Plan will automatically terminate on the date of the divorce or annulment; or
 - F. Termination of coverage of a child. Coverage of an employee or member of the Group's child under this Benefit Plan will terminate on the date the child no longer qualifies under Section Two of this booklet or, if later, the next contributions due date after the Group and/or the Claims Administrator receives notice of termination.
3. **Temporary Continuation of Coverage.** Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer sponsored group health plans must offer employees and their families the

opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write your Group to find out if you are entitled to temporary continuation of coverage under COBRA.

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 twenty four months 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 the 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 Associate Vice President of Human Resources and/or Director of Benefits of the Group or a person duly authorized in writing by the Associate Vice President of Human Resources and/or Director of Benefits 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 Associate Vice President of Human Resources and/or Director of Benefits of the Group or by a person duly authorized in writing by the Associate Vice President of Human Resources and/or Director of Benefits of the Group.
14. **Changes in This Benefit Plan.** The Group may unilaterally change this Benefit Plan at any time in accordance with Section Eighteen, Paragraph 13.
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; ERISA.** 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.

The Group may also have additional responsibilities as the “plan administrator” as defined by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The “plan administrator” is the Group, or a third party appointed by the Group. The Claims Administrator is not the ERISA plan administrator.

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. **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.

23. **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.

- 24. **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 26. To initiate a grievance, just contact the Claims Administrator. The Claim 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's Customer Service Department by phone, in person or in writing to file a grievance. You or your designee has up to 180 calendar days from when you received the decision you are asking the Claims Administrator to review 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.
25. **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.

- B. **Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one

business day of receipt of all information necessary to make a decision. If additional information is needed, 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.

- C. **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.

- D. **Notice of Initial Adverse Determination.** A notice of adverse determination (notice that a service is not Medically Necessary or is experimental/investigational) will include the reasons, including clinical criteria and clinical rationale, for 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.

- E. **Internal Appeals of Adverse Determinations.** You, your designee, and/or your health care provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing. You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. 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.

- F. **Notice of Determination of Internal Appeal.** The notice of determination of your internal appeal will indicate that it is a “final adverse determination” and will include the clinical rationale for 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.
- G. **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 27 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.

26. **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 Benefit Plan.

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

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

In general, you may not request an external appeal unless 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 Benefit Plan, except in cases where You fail to pay any required contribution to the cost of coverage under the Benefit Plan. You do not have the right to an external appeal of any other determinations, even if those other determinations affect your coverage.

- C. **Requesting an External Appeal.** If you meet the conditions described above, you or your authorized representative may request an external appeal by completing and filing a self-insured external appeal application with 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.

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