These are your

ST. JOHN FISHER COLLEGE

MEDICAL BENEFITS PLAN

PPO HDHP OPTION

2021

This Booklet explains your St. John Fisher College Preferred Provider Organization HDHP Option health benefits plan (the "Benefit Plan"). These benefits are sponsored and funded by St. John Fisher College (the "Group"). Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield ("Excellus BlueCross BlueShield"), administers claims for benefits under the Benefit Plan on behalf of the Group and does not insure your benefits. Excellus BlueCross BlueShield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Excellus BlueCross BlueShield is a nonprofit independent licensee of the BlueCross BlueShield Association. You should keep this Booklet with your other important papers so that it is available for your future reference.

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

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

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

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

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SECTION ONE - INTRODUCTION AND DEFINITIONS

1. **Your Coverage under this Benefit Plan.** The Group has created the self-funded Benefit Plan effective January 1, 2018, as most recently amended and restated effective as of January 1, 2021. Under the Benefit Plan, the benefits described in this booklet will be provided to employees of the Group and their covered family members, subject to the Group's eligibility requirements. You should keep this booklet with your other important papers so that it is available for your future reference.

2. **Definitions**.

   A. **Acute.** The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

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

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

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

   (1) **Facilities in the Service Area.**

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

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

   (2) **Facilities Outside the Service Area.**

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

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

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

For a Professional Provider or a Provider of Additional Health Services in the Service Area, the Allowable Expense will be 80% of the Centers for Medicare and Medicaid Services Provider fee schedule (CMS Fee Schedule), as applicable to the provider type, unadjusted for geographic locality, or the Professional Provider or a Provider of Additional Health Services' charge, if less.

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

(4) **For a Professional Provider or a Provider of Additional Health Services Outside the Service Area.**

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

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

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

(6) **Physician-Administered Pharmaceuticals.**

For Physician-administered pharmaceuticals, the Benefit Plan uses gap methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or the Claim Administrator based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a

Physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.

(7) **In Vitro Diagnostic Test for the Detection of SARS-CoV-2.** Effective as of March 13, 2020, the Allowed Amount for a Non-Participating Provider for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 is the Non-Participating Provider's publicly listed price for such test, or such lower rate as the Claims Administrator may negotiate with the Non-Participating Provider.

The Non-Participating Provider's actual charge may exceed the Benefit Plan's Allowable Expense. You must pay the difference between the Allowable Expense and the Non-Participating Provider's charge. Contact the Claim Administrator at the number on your ID card or visit the Claim Administrators website for information on your financial responsibility when you receive services from a Non-Participating Provider.

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

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

D. **Claims Administrator.** The Claims Administrator is Excellus BlueCross BlueShield or the Prescription Drug Benefit Manager, as applicable.

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

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

G. **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.)

H. **Effective Date.** The date your coverage under this Benefit Plan begins. Coverage begins 12:01 a.m. on the Effective Date.

I. **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.

J. **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.

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

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

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

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

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

None of the following are considered Hospitals:

(1) Places primarily for nursing care;

(2) Skilled Nursing Facilities;

(3) Convalescent homes or similar institutions;

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

(5) Health resorts, spas, or sanitariums;

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

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

(8) Free standing ambulatory surgical centers.

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

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

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

P. **Medical Director.** The person designated by Excellus BlueCross BlueShield to monitor quality of care and appropriate utilization of health services.

Q. **Medical Necessity.** See Section Three of this Booklet.

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

S. **Mental Health Disorder.** A Mental Health Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

T. **Non-Participating Provider.** This Benefit Plan covers certain health care services described in this booklet when you receive the covered services from Non-Participating Providers. When you receive Out-of-Network Benefits, you will incur higher out-of-pocket expenses. In addition to any applicable Copayment or Coinsurance, you will be responsible for paying any difference between the Allowable Expense and the provider's charge.

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

V. **Out-of-Pocket Limit:** The most you pay during a Calendar Year in Deductibles, Copayments and Coinsurance before the Benefit Plan begins to pay 100% of the Allowable Expense for covered services. This limit never includes your premium, balance billing charges or the cost of health care services the Benefit Plan does not cover.

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

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

X. **Prescription Drug Benefit Manager.** Express Scripts, P.O. Box 14711, Lexington, KY 40512-4711.

Y. **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.

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

AA. **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.

BB. **Service Area**. The geographic territory within which Excellus BlueCross BlueShield is licensed to use the BlueCross and BlueShield service marks. The Excellus BlueCross BlueShield Service Area consists of Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Oswego; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson counties.

CC. **Skilled Care.** A service that Excellus BlueCross BlueShield determines is furnished by or under the direct supervision of licensed medical personnel to assure the safety of the patient and achieve the medically desired results as defined by medical guidelines. A service is not considered a skilled service merely because it is performed or supervised by licensed medical personnel. However, it is a service that cannot be safely and adequately self-administered or performed by the average non-medical person without the supervision of such personnel.

DD. **Skilled Nursing Facility.** A facility accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or qualified as a Skilled Nursing Facility under Medicare. The Benefit Plan will provide coverage for your care in a Skilled Nursing Facility only if Excellus BlueCross BlueShield determines that the care is Skilled Care.

EE. **Substance Use Disorder.** A Substance Use Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

FF. **"You", "Your", and "Yours"**. Throughout this Booklet, the words "you", "your" and "yours" refers to you, the employee or his/her dependents to whom this Booklet is issued. If other than individual coverage applies, then, in most cases, the word "you" also includes any family members, including domestic partners, who are covered under this Benefit Plan.

SECTION TWO - WHO IS COVERED

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

   A. Your spouse. If you are divorced or your marriage has been annulled, your former spouse is not covered.

   B. Your domestic partner. A domestic partner is a person of the same or opposite sex for which you submit the proof of domestic partnership and financial interdependence in the form of:

      (1) Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or

      (2) For domestic partners residing where registration does not exist, by an alternative affidavit of domestic partnership.

         (a) The affidavit must be notarized and must contain the following:

            I. The partners are both 18 years of age or older and are mentally competent to consent to contract;

            II. The partners are not related by blood in a manner that would bar marriage under laws of the state in which they live;

            III. The partners have been living together on a continuous basis prior to the date they enroll for coverage under the Benefit Plan;

            IV. Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and

         (b) Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and

         (c) Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:

            I. A joint bank account;
            II. A joint credit card or charge card;
            III. Joint obligation on a loan;

IV. Status as an authorized signatory on the partner's bank account, credit card or charge card;
V. Joint ownership of holdings or investments;
VI. Joint ownership of residence;
VII. Joint ownership of real estate other than residence;
VIII. Listing of both partners as tenants on the lease of the shared residence;
IX. Shared rental payments of 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, etc. (need not be shared 50/50);
XII. Shared household budget for purposes of receiving government benefits;
XIII. Status of one (1) 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., babysitting, day care, school bills (need not be shared 50/50);
XVIII. Execution of wills naming each other as executor and/or beneficiary;
XIX. Designation as beneficiary under the other's life insurance policy;
XX. Designation as beneficiary under the other's retirement benefits account;
XXI. Mutual grant of durable power of attorney;
XXII. Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
XXIII. Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
XXIV. Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

C. Your children who are under the age of 26. Coverage lasts until the end of the month of the child's 26th birthday. Your children 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. Children-in-law (spouses of children) and grandchildren are not covered.

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

"Children" include: your natural children; a legally adopted child; a step child; a child for which you have been appointed legal guardian or granted legal custody by court order; a child of a domestic partner; 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 dependents as they pertain to eligibility for coverage under this Benefit Plan.

2. **Types Of Coverage Other Than Individual Coverage.** The Benefit Plan offers different types of coverage in addition to employee only coverage:

A. Family coverage - you may elect coverage for you, your spouse or domestic partner and your eligible children; or you and your eligible children; or

B. Two person coverage - you may elect two-person coverage if your family unit consists of you and your eligible spouse or domestic partner, or you and an eligible child.

C. Child(ren) Coverage – if child(ren) coverage applies, then you and your child or or children as described 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. No one else can be substituted for those persons. The Group and Excellus BlueCross BlueShield have administrative rules to determine which types of coverage are available to members of the Group. You are only entitled to the types of coverage for which the Group (or Excellus BlueCross BlueShield on behalf of the Group) receives your contribution and for which you are otherwise eligible. You may call Excellus BlueCross BlueShield if you have any questions about which type of coverage applies to you.

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

A. If you, the employee or member of the Group, elect coverage before becoming eligible for coverage or within 30 days of becoming eligible, coverage begins at 12:01 a.m. on the date you become eligible;

B. If you, the employee or member of the Group, do not elect coverage upon becoming eligible or within 30 days of becoming eligible, you must wait until the Group's open enrollment period, except as provided in Paragraph 4 below. Coverage then begins at 12:01 a.m. at the beginning of the Calendar Year after the next open enrollment period (the "Plan Year" is the twelve-month period from January 1st to December 31st each year); or

C. If you, the employee or member of the Group, marry or enter into a domestic partnership while covered, and Excellus BlueCross BlueShield receives notice of such marriage or domestic partnership within 30 days thereafter, coverage for the spouse or domestic partner and any eligible dependents for whom you elect coverage starts at 12:01 a.m. on the date of such marriage or domestic partnership or the date your election form is completed, whichever is later; otherwise, coverage for the spouse or domestic partner will start at 12:01 a.m. at the beginning of the Calendar Year after the next open enrollment period.

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

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

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

(1) Termination of employment;

(2) Termination of the other plan or contract;

(3) Death of the spouse 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 on the first day of the month following the request for enrollment, when you are entitled to special enrollment based on marriage or commencement of a domestic partnership.

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

A. **To Add a Spouse or Child.** If you need to add a spouse or child to your coverage, you must complete and return to the Group an enrollment form for this purpose together with any requested documentation. The addition of a child will be effective as of the date of birth or adoption making the child eligible for coverage under Paragraph 1, if you return to your employer a completed enrollment form and requested documents within 30 days of the birth or adoption. The addition of a spouse or other dependent will be effective as of the date of the marriage or other qualifying event making such individual eligible for coverage under this section or the date the election form is completed, whichever is later, if you return to your employer a completed enrollment form and requested documents within 30 days of the applicable event. If you do not return a completed election form and the requested documentation within 30 days, you will not be able to add the dependent until you reach the annual open enrollment period or experience another qualifying event. Any changes requested during the annual open enrollment, including the addition of a dependent, will be effective the following January 1.

B. **When Coverage of a Spouse, Domestic Partner or Child Terminates.** If you have other than Employee Only coverage, you must notify the Benefit Plan of any event that affects your coverage, including, but not limited to, your divorce; separation, termination of a domestic partnership; the death of your spouse or domestic partner; a Member becoming Medicare eligible, or a child reaching the age at which coverage terminates, or otherwise experiencing an event which would normally result in termination of dependent coverage.

SECTION THREE - MEDICAL NECESSITY AND PRIOR APPROVAL

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

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

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

   A. Reports in peer reviewed medical literature;

   B. Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;

   C. Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment;

   D. The opinion of health professionals in the generally recognized health specialty involved;

   E. The opinion of the attending Professional Providers, which have credence but do not overrule contrary opinions; and

   F. Any other relevant information brought to its attention.

   Services will be deemed Medically Necessary only if:

   A. They are appropriate and consistent with the diagnosis and treatment of your medical condition;

   B. They are required for the direct care and treatment or management of that condition;

   C. If not provided, your condition would be adversely affected;

   D. They are provided in accordance with community standards of good medical practice;

E. They are not primarily for the convenience of you, your family, the Professional Provider, or another provider;

F. They are the most appropriate service and rendered in the most efficient and economical way and at the most economical level of care which can safely be provided to you; and

G. When you are an inpatient, your medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided to you in any other setting (e.g., outpatient, physician's office, or at home).

2. **Service or Care Must Be Approved Standard Treatment.** Except as otherwise required by law, no service or care rendered to you will be considered Medically Necessary unless Excellus BlueCross BlueShield determines that the service or care is: consistent with the diagnosis and treatment of your medical condition; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative.

3. **Services Subject To Prior Approval**. If Services are rendered by a Participating Provider, your provider is required to obtain preauthorization for certain services covered under this Benefit Plan. If Services are rendered by a Non-Participating Provider, you are required to obtain preauthorization for certain services covered under this Benefit Plan. A list of Services that require preauthorization can be obtained by visiting www.excellusbcbs.com. This list is subject to change and is updated from time to time. To verify whether or not a specific Service requires preauthorization, or to request a paper copy (free of charge) of the list of Services that require preauthorization, please contact the customer service number listed on your ID card.

4. **Prior Approval Procedure**. If you seek coverage for any services that require prior approval (as stated 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 Excellus BlueCross BlueShield's decision, you may appeal the decision in accordance with the Claims and Appeals procedure in Section Eighteen.

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

SECTION FOUR - COST SHARING EXPENSES

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

   A. Your Coinsurance for In-Network Benefits is 20%.

   B. Your Coinsurance for Out-of-Network Benefits is 40%.

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

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

   A. If you have individual coverage you must pay the first $1,550 (In-Network Benefits) or $3,100 (Out-of-Network Benefits) of Allowable Expenses, excluding Copayments, incurred under the Benefit Plan during each Calendar Year.

   B. If you have two person, children or family coverage, the Deductible applies to each person covered under the Benefit Plan. However, after Deductible payments for any and all persons covered under the Benefit Plan total $3,100 (In-Network Benefits) or $6,200 (Out-of-Network Benefits) in a Calendar Year, no further Deductible will be required for an person covered under the Benefit Plan for the applicable Calendar Year.

   The amounts you pay towards the Deductible for In-Network Benefits do not count towards the amounts you pay towards the Deductible for Out-of-Network Benefits and vice versa. This means that the Deductible for In-Network Benefits is separate and distinct from the Deductible for Out-of-Network Benefits.

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

   A. If you have individual coverage, the total Out-of-Pocket Limit is $3,400 (In-Network Benefits) or $6,800 (Out-of-Network Benefits).

B. If you have two person, children or family coverage, the total Out-of-Pocket Limit is $6,800 (In-Network Benefits) or $13,600 (Out-of-Network Benefits).

With respect to (B) above, once a person within a family has paid $6,650 for In-Network Benefits in a Calendar Year in Coinsurance, Copayments and Deductibles, the Benefit Plan will provide coverage for In-Network Benefits at 100% of the Allowable Expense for the rest of that Calendar Year for that person.

If you use a combination of Participating Providers and Non-Participating Providers, your Out-of-Pocket Limits are separate amounts and are not combined. This means that you will be required to satisfy the Out-of-Pocket Limit amount for Participating Providers and Non-Participating Providers separately. The amounts you pay towards satisfaction of the Participating Provider Out-of-Pocket Limit do not count towards satisfaction of the Non-Participating Provider Out-of-Pocket Limit and the amounts you pay towards satisfaction of the Non-Participating Provider Out-of-Pocket Limit do not count towards satisfaction of the Participating Provider Out-of-Pocket Limit. Payment for any charges for a Service provided by a Non-Participating Provider that exceeds the Allowable Expense will be your responsibility.

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

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

When you receive services from a Non-Participating Provider, you must always pay the difference between the Allowable Expense and the provider's charge.

SECTION FIVE - INPATIENT CARE

1. **In a Facility.** If you are a registered bed patient in a Facility, the Benefit Plan will provide coverage for most of the services provided by the Facility, subject to the conditions and limitations in Paragraph 3 below. The services must be given to you by an employee of the Facility, the Facility must bill for the services, and the Facility must retain the money collected for the services.

2. **Services Not Covered.** The Benefit Plan will not provide coverage for:

   A. Additional charges for special duty nurses;

   B. Private room, unless it is Medically Necessary for you to occupy a private room. If you occupy a private room in a Facility and Excellus BlueCross BlueShield determines that a private room is not Medically Necessary, the Benefit Plan's coverage will be based upon the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room;

   C. Blood, except the Benefit Plan will provide coverage for blood required for the treatment of hemophilia. However, the Benefit Plan will provide coverage for blood and blood products when participation in a voluntary blood replacement program is not available to you;

   D. Non-medical items, such as telephone or television rental;

   E. Medications, supplies, and equipment (other than internal prosthetics), which you take home from the Facility; or

   F. Custodial care (See Section Fifteen).

3. **Conditions for Inpatient Care; Limitations on Number of Days of Care.** Inpatient Facility care is subject to the following conditions and limitations:

   A. **Inpatient Hospital Care.** The Benefit Plan will provide coverage when you are required to stay in a Hospital for Acute medical, surgical or mental health care and substance use disorder.

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

      I. A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;

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

and, in other states, to similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator.

The Benefit Plan also covers inpatient mental health care services relating to the diagnosis and treatment of Mental Health Disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Law Article 30; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Benefit Plan, and that provide (at a minimum) those services and treatments identified in the most recent McKesson InterQual criteria for a psychiatric residential treatment center or in such other comparable criteria recognized by the Benefit Plan.

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

D. The Benefit Plan also covers inpatient substance use services relating to the diagnosis and treatment of a Substance Use Disorder received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission or a national accreditation organization recognized by the Claims Administrator as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

D. **Skilled Nursing Facility.** The Benefit Plan will provide coverage for In-Network care in a Skilled Nursing Facility if Excellus BlueCross BlueShield determines that hospitalization would otherwise be Medically Necessary for the care of your condition, illness, or injury for up to 45 days in a Calendar Year. In-Network Benefits and Out-of-Network Benefits for a Skilled Nursing Facility will both be counted toward the 45 day Calendar Year limit described above.

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

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

5. **Mastectomy Care.** The Benefit Plan's coverage of inpatient Hospital care includes coverage of an inpatient Hospital stay following a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer. The length of stay will be determined by you and your Professional Provider. The Benefit Plan will also provide coverage for prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

6. **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.

7. **Internal Prosthetic Devices.** The Benefit Plan covers inpatient Hospital care for internal prostheses that are surgically implanted and Medically Necessary for anatomical repair or reconstructive purposes. Internal prosthetic devices are designed to replace all or part of a permanently inoperative, absent, or malfunctioning body organ. Examples of internal

prosthetic devices include cardiac pacemakers, implanted cataract lenses, and surgically implanted hardware necessary for joint repair or reconstruction.

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. **Payments for Inpatient Care**.

In-Network. In-Network Benefits, other than for routine newborn nursery care, are covered at 80% of the Allowable Expense, after Deductible. In-Network Benefits for routine newborn nursery care are covered at 80% of the Allowable Expense.

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

SECTION SIX - OUTPATIENT CARE

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

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

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

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

2. **Pre-Admission Testing.** The Benefit Plan will provide coverage for tests ordered by a Professional Provider that are given to you as a preliminary to your admission to the Facility as a registered bed patient for surgery if all of the following conditions are met:

   A. They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;

   B. A reservation has been made for the Facility bed and/or the operating room before the tests are given;

   C. You are physically present at the Facility when these tests are given; and

   D. Surgery actually takes place within 7 days after the tests are given.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. **Injectable Drugs.** The Benefit Plan will provide coverage for drugs that are administered by injection during the course of an outpatient visit covered under this section.

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

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

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

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

   If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, the Benefit Plan covers mammograms as recommended by the Member's Provider.

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

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

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

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

9. **Cervical Cytology Screenings (Pap Smears).** The Benefit Plan will provide coverage for Members 18 years of age or older. The screenings may be provided in the outpatient department of a Facility under this Section or in a Professional Provider's office pursuant to Section Nine. 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 for routine cervical cytology screenings are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic cervical cytology screenings are covered at 80% of the Allowable Expense, after Deductible.

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

10. **Screening Colonoscopy.** The Benefit Plan will provide coverage for colonoscopies to screen for colon cancer in asymptomatic Members.

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

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

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

worker who has at least three years of additional experience in psychotherapy; a licensed mental health counselor; a psychiatric nurse, licensed as a nurse practitioner; a licensed marriage and family therapist; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator.

11.

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

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

12. **Substance Use Outpatient Services.** The Benefit Plan covers outpatient substance use services relating to the diagnosis and treatment of Substance Use Disorders, including but not limited to partial Hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling and medication-assisted treatment. Such coverage is limited to Facilities in New York State that are certified or otherwise authorized by OASAS to provide outpatient Substance Use Disorder services, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission or a national accreditation organization recognized by the Claims Administrator as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a Substance Use Disorder provided by an OASAS credentialed provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

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

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

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

13. **Covered Therapies.** The Benefit Plan will provide coverage for related rehabilitative physical therapy and physical, occupational, and speech therapy when services are rendered by a licensed physical therapist, occupational therapist, or speech language pathologist or audiologist and when Excellus BlueCross BlueShield determines that your condition is subject to significant clinical improvement through relatively short-term therapy. The coverage for related rehabilitative physical therapy and physical, occupational, and speech therapy shall be subject to an in and out of network limit of up to 45 combined visits for physical, speech, and occupational therapy. In-Network Benefits and Out-of-Network Benefits will both be counted toward the 45-day limit described above

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

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

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

14. **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 80% of the Allowable Expense, after Deductible.

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

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

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

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

16. **Infertility Treatment Services.** The Benefit Plan will provide coverage for Medically Necessary outpatient Facility care in connection with infertility treatment services provided by a Professional Provider pursuant to Section Nine.

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

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

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

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

18. **Biofeedback.** The Benefit Plan will provide coverage for biofeedback.

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

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

SECTION SEVEN - HOME CARE

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

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

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

   A. A home care treatment plan is established and approved in writing by your Professional Provider;

   B. If provided by a certified or licensed home health agency or home care services agency, you apply through your Professional Provider to the home health agency or home care services agency with supporting evidence of your need and eligibility for home care; and

   C. The home care is related to an illness or injury for which you were hospitalized or for which you otherwise would have been hospitalized or confined in a Skilled Nursing Facility. This home care must be Medically Necessary at a skilled or acute level of care.

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

3. **Home Care Services Covered.** Home health care will consist of one or more of the following:

   A. Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse;

   B. Part-time or intermittent home health aide services which consist of primarily rendering direct care to you;

   C. Physical, occupational, or speech therapy if provided by the home health care agency; and

   D. Medical supplies, drugs, and medications prescribed by your physician and laboratory services by or on behalf of the home health agency or home care services agency to the extent such items would have been covered under this Benefit Plan if you were an inpatient in a Hospital or Skilled Nursing Facility.

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

4. **Failure to Comply with Home Care Treatment Plan.** If you fail or are unable to comply with the home care treatment plan, benefits for your plan of home care will be terminated.

5. **Payments for Home Care**.

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

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

SECTION EIGHT - HOSPICE CARE

1. **Eligibility for Benefits.** In order to receive these benefits, which are non-aggressive services provided to maintain the comfort, quality, and dignity of life to the terminally ill patient, you must meet the following conditions:

   A. The attending physician estimates your life expectancy to be six months or less; and

   B. Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.

2. **Hospice Organizations.** In New York State the Benefit Plan will provide coverage only for hospice care provided by a hospice organization which has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the hospice organization must have an operating certificate issued under criteria similar to those used in New York by a state agency in the state where the hospice care is provided, or it must be approved by Medicare.

3. **Hospice Care Benefits.** The Benefit Plan will provide coverage for the following services when provided by a hospice:

   A. Bed patient care provided by the hospice organization either in a designated hospice unit or in a regular hospital bed;

   B. Day care services provided by the hospice organization;

   C. Home care and outpatient services which are provided and billed through the hospice and which may include at least the following:

      (1) Intermittent nursing care by an R.N., L.P.N. or home health aide;

      (2) Physical therapy;

      (3) Speech therapy;

      (4) Occupational therapy;

      (5) Respiratory therapy;

      (6) Social services;

      (7) Nutritional services;

      (8) Laboratory examinations, X-rays, chemotherapy, and radiation therapy when required for control of symptoms;

      (9) Medical supplies;

(10) Drugs and medications that require a prescription by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary; provided that the Benefit Plan will not provide coverage when the drug or medication is of an experimental nature;

(11) Durable medical equipment; and

(12) Bereavement services provided to your family during illness, and until one year after death; and

D. Medical care provided by a physician.

4. **Number of Days of Care.** The Benefit Plan will provide coverage for an unlimited number of hospice care visits. 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. **Payments for Hospice Care**.

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

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

SECTION NINE - PROFESSIONAL SERVICES

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

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

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

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

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

      Out-of-Network. Out-of-Network Benefits are covered at 60% 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 80% of the Allowable Expense, after Deductible.

      Out-of-Network. Out-of-Network Benefits are covered at 60% 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 80% of the Allowable Expense, after Deductible.

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

2. **Covered Therapies.** The Benefit Plan will provide coverage for related rehabilitative physical therapy and physical, occupational, and speech therapy when services are

rendered by a licensed physical therapist, occupational therapist, or speech language pathologist or audiologist and when it is determined that your condition is subject to significant clinical improvement through relatively short-term therapy. The coverage for related physical therapy and physical, occupational, and speech therapy shall be subject up to an aggregate of 45 visits per Member per Calendar Year. In-Network Benefits and Out-of-Network Benefits will both be counted toward the 45-visit maximum.

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

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

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

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 the Benefit Plan.

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

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

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

A. The Benefit Plan will provide benefits when:

(1) You seek the second surgical opinion after your surgeon determines your need for surgery; and

(2) The second surgical opinion is rendered by a physician

(a) Who is a board certified specialist; and

(b) Who, by reason of his or her specialty, is an appropriate physician to consider the proposed surgical procedure; and

(3) The second surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under this Benefit Plan if such surgery was performed; and

(4) You are examined in person by the physician rendering the second surgical opinion; and

(5) The specialist who renders the opinion does not also perform the surgery.

B. The Benefit Plan will provide coverage for a third surgical opinion if the first two opinions do not agree. The rules described above also apply to the third surgical opinion.

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

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

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 covered at 80% of the Allowable Expense, after Deductible.

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

6. **Maternity Care.** The Benefit Plan will provide coverage for:

A. **Normal Pregnancy.** Maternity care includes the first visit upon which a positive pregnancy test is determined. It also includes all subsequent prenatal and postpartum care. These benefits include the services of a licensed midwife, under qualified medical direction, affiliated or practicing in conjunction with a Facility licensed under the New York Public Health Law (or comparable law of the state where services are provided). Any laboratory testing or diagnostic imaging is not covered under this Paragraph. These items are subject to the applicable coverage and cost sharing under the appropriate provisions.

In-Network. In-Network Benefits, other than those services that are considered preventive services in accordance with Section Ten, are covered

at 80% of the Allowable Expense, after Deductible. In-Network Benefits for preventive services are covered at 100% of the Allowable Expense.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 80% of the Allowable Expense, after Deductible.

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

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

A. **Preventive Health Services.** The 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 In-Network periodic adult routine physical examinations in accordance with the United States Task Force on Preventative Care. Coverage is limited to one (1) exam per Calendar Year. Specifically, for covered individuals a routine physical examination will be covered as follows:

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

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

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

recommended by the American Academy of Pediatrics, in accordance with the Academy's recommended schedule.

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

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

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

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

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

Out-of-Network. Out-of-Network Benefits are covered at 60% 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 80% of the Allowable Expense, after Deductible.

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

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

Routine eye examinations are limited to one (1) exam each Calendar Year.

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

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

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

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

Routine hearing examinations are limited to one (1) exam per Calendar Year.

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

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

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

(4) **Hearing Aids.** The Benefit Plan will provide coverage for up to two (2) hearing aids per Member under the age of 19, every three (3) Calendar Years.

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

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

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

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

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

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 covered at 80% of the Allowable Expense, after Deductible.

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

9. **Telemedicine Program.** The Benefit Plan provides coverage for telephone consultations, e-mail consultations and online internet consultations between you and providers that participate in the telemedicine program for non-emergent medical conditions. The telemedicine program is provided through MDLIVE. Not all Participating Providers participate with MDLIVE. For a listing of providers that participate with MDLIVE, you may check the participating provider directory by visiting www.mdlive.com or by contacting MDLIVE, toll free, at 866-692-5045.

Telemedicine is the delivery of healthcare services through the use of privacy compliant technology. It allows you to connect with a provider via video conference, telephone or e-mail for the purposes of diagnosis, consultation and treatment; just as would be provided during a face to face office visit. The telemedicine program is an optional service provided to you and your covered Dependents. To utilize this service, you must register by calling MDLIVE, toll free at 866-692-5045, or by visiting www.mdlive.com. You will need to provide your name, the patient's name (if you are not calling for yourself), the primary Member's and patient's date of birth and zip code.

Common examples of when to use MDLIVE for non-emergent medical care, include, but are not limited to the following:

(A) Your primary care doctor is not available.

(B) You are traveling and in need of non-emergent medical care.

(C) During or after normal business hours, nights, weekends and holidays.

(D) To request (non-DEA controlled) prescriptions or refills. MDLIVE providers prescribe drugs or medications only if the provider deems it is Medically Necessary.

If you have questions concerning MDLIVE, the available care or coverage, or your benefits, please contact MDLIVE at the telephone number or internet address listed above. In the unlikely event that MDLIVE is unable to resolve your inquiry, you may, as with any medical service, follow the claim and appeal process that is described elsewhere in this booklet.

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

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

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

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

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

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

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

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

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

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

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

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

13. **Injectable Drugs.** The Benefit Plan will provide coverage for drugs that are administered by injection during the course of an outpatient visit covered under this section.

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

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

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

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

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, the Benefit Plan covers mammograms as recommended by the Member's Provider.

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

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

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

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

15. **Gynecological Services.** The Benefit Plan will provide coverage, subject to the limitations stated below, for gynecology visits, including coverage for cervical cancer and its precursor states each Calendar Year for women 18 years of age and older. The screenings may be provided in the outpatient department of a Facility pursuant to Section Six or in a Professional Provider's office pursuant to this Section. 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 screenings are covered at 100% of the Allowable Expense. In-Network Benefits for diagnostic gynecological visits are covered at 80% of the Allowable Expense, after Deductible.

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

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

A. **Men with a Prior History of Prostate Cancer**. The Benefit Plan will provide coverage for routine testing for men of any age who have had a prior history of prostate cancer.

B. **Men at Risk**. The Benefit Plan will provide coverage for one routine exam in each Calendar Year for men over the age of 40 who have a family history of prostate cancer or who have other risk factors for prostate cancer.

C. **Men 50 Years of Age or Older**. The Benefit Plan will provide coverage for one routine exam in each Calendar Year for men 50 years of age and older.

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

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

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

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

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

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

18. **Screening Colonoscopy.** The Benefit Plan will provide coverage for colonoscopies to screen for colon cancer in asymptomatic Members.

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

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

19. **Mental Health Disorder Outpatient Services.** The Benefit Plan covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment

of Mental Health Disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy, a licensed marriage and family therapist, or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator.

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

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

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

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

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

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

21. **Chiropractic Care.** The Benefit Plan will provide coverage for Medically Necessary services rendered in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column. However, such services must be:

    A. Rendered by a provider licensed to provide such services; and

    B. Determined to be Medically Necessary.

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

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

22. **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 80% of the Allowable Expense, after Deductible.

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

23. **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 80% of the Allowable Expense, after Deductible.

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

24. **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 80% of the Allowable Expense, after Deductible.

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

25. **Infertility Treatment Services**. The Benefit Plan will provide coverage for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

A. **Basic Infertility Services.** Basic infertility services will be provided to a covered person who is an appropriate candidate for infertility treatment. Infertility is determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine.

Basic infertility services include:

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

XI. Sono-hystogram; and
XII. Testis biopsy.

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

B. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, the Plan will provide coverage for comprehensive infertility services. Comprehensive infertility services include:

I. Artificial insemination;
II. Hysteroscopy;
III. Laparoscopy;
IV. Laparotomy;
V. Ovulation induction and monitoring; and
VI. Pelvic ultrasound.

C. **Exclusions and Limitations.** The Benefit Plan does not Cover:

- In-vitro fertilization;
- Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- Costs associated with an ovum or sperm donor, including the donor's medical expenses;
- Cryopreservation and storage of sperm, ova, and embryos;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for covered persons acting as surrogate mothers);
- Cloning; or
- Medical and surgical procedures that are experimental or investigational.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. The Benefit Plan will not discriminate based on your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

D. **Copayments and Coinsurance.** The benefits of this Paragraph are subject to any applicable Deductible, Copayments or Coinsurance provision under this Section Nine for similar services.

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

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

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

27. **Bone Density Testing.** The Benefit Plan will cover bone mineral density measurements and tests for the detection of osteoporosis. The Benefit Plan will apply standards and guidelines that are consistent with the criteria of the federal Medicare program or the National Institutes of Health ("NIH") to determine appropriate coverage for bone density testing under this Paragraph. Coverage will be provided for tests covered under Medicare or consistent with the NIH criteria including, as consistent with such criteria, dual-energy x-ray absorptiometry. When consistent with the Medicare or NIH criteria, coverage, at a minimum, will be provided for those Members.

A. Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

B. With symptoms or conditions indicative of the presence, or a significant risk, or osteoporosis; or

C. On a prescribed drug regimen posing a significant risk of osteoporosis; or

D. With lifestyle factors to the degree of posing a significant risk of osteoporosis; or

E. With such age, gender, and/or physiological characteristics that pose a significant risk of osteoporosis, including women over age 65 and women over age 60 who are at increased risk for osteoporotic fractures.

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

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

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, Coinsurance or Copayment provisions under the Benefit Plan for similar services. For example, any Deductible, Coinsurance or Copayment that applies to physical therapy visits generally will also apply to physical therapy services covered under this section. Any Deductible, Coinsurance or Copayment that applies to physician medical services; specialist office visits will apply to assistive communication devices covered under this section.

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

2. **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, subject to the Claims Administrator's supply limits and utilization management requirements;

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

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

The Benefit Plan will pay for diabetes self-management education and diet information provided by your Professional Provider or Authorized Medical Personnel, or their staff, in connection with Medically Necessary visits upon the diagnosis of diabetes, a significant change in your symptoms, the onset of a condition necessitating changes in self-management or where re-education or refresher education is Medically Necessary, as determined by the Claims Administrator. When such education is provided as part of the same office visit for diagnosis or treatment of diabetes, payment for the office visit shall include payment for the education. The Benefit Plan will also pay for home visits, when Medically Necessary.

Education is also covered when provided by the following 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. Except to the extent prohibited by law, In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible.

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

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

   Durable medical equipment is equipment that can withstand repeated use, can normally be rented and reused by successive patients, is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a person's home. Please contact Excellus BlueCross BlueShield for a copy of Policy Number 1.01.00, Durable Medical Equipment – Standard and Non-Standard, for more information on coverage of durable medical equipment.

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

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

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

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

4. **External Prosthetic Devices**. The Benefit Plan will provide coverage for external prosthetic devices and their replacements necessary to relieve or correct a condition caused by an injury or illness. Your physician must order the prosthetic device for your condition before its purchase. Although the Benefit Plan requires that a physician prescribe the device, this does not mean that it will automatically be determined that you need it. Excellus BlueCross BlueShield will determine if the prosthetic device is Medically Necessary. The Benefit Plan will only provide benefits for prosthetic devices that can adequately meet the needs of your condition at the least cost.

   A prosthetic device is an artificial organ or body part, including, but not limited to, artificial limbs and eyes. Dentures or other devices used in connection with the teeth are also not covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. The Benefit Plan will provide benefits

for contact lenses when they perform the function of the human lens and are Medically Necessary because of intra-ocular surgery.

Not included in this benefit are: the cost of rental, purchase, repair, or maintenance of prosthetic devices because of misuse, loss, natural disaster, or theft or the cost of deluxe items, unless approved in advance by the Medical Director. The Benefit Plan will not provide coverage for delivery or service charges, or for routine maintenance related to prosthetic devices. Please contact Excellus BlueCross BlueShield for a copy of Policy Number 1.01.08, Prosthetic Devices, for more information on coverage of Prosthetics.

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

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

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

5. **Orthotic Devices.** The Benefit Plan will provide coverage for orthotic devices that are rigid or semi-rigid (having molded plastic or metal stays) and their replacements when the devices are necessary to: support, restore, or protect body function; redirect, eliminate, or restrict motion of an impaired body part: or relieve or correct a condition caused by an injury or illness. Orthotic devices include orthopedic braces and custom-built supports; including foot orthotics. Your physician must order the orthotic device for your condition before its purchase. Although the Benefit Plan requires that a physician prescribe the device, this does not mean that it will automatically be determined that you need it. Excellus BlueCross BlueShield alone will determine if the orthotic device is Medically Necessary. The Benefit Plan will only provide benefits for an orthotic device that can adequately meet the needs of your condition at the least cost. Please contact Excellus BlueCross BlueShield for a copy of Policy Number 1.01.25, Orthotics, for more information on coverage of Orthotics.

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

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

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

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

supplies include: bandages; surgical gloves, tracheotomy supplies; and compression stockings.

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

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

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

7. **Ambulance Service.** In addition to the services described in paragraph 8 below, the Benefit Plan will also provide coverage for the following Medically Necessary services provided by a certified ambulance service:

   A. Ground, water or air ambulance service for an urgent condition to the nearest Hospital where Emergency Services can be performed. 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, water or air transportation between Facilities when the transport is to the nearest Hospital, Facility or setting in any of the following circumstances:

      (1) From a Non-Participating Provider Hospital to the nearest Participating Provider Hospital;

      (2) To a Hospital that provides a higher level of care that was not available at the original Hospital;

      (3) To a more cost effect Acute care Facility; or

      (4) From an Acute care Facility to a sub-Acute setting.

      In addition to the above, the provider of the specialized services must be the nearest one with the required capabilities to treat the patient.

   C. Limitations.

      (1) The Benefit Plan does not cover non-ambulance transportation such as ambulette, van or taxi cab.

      (2) Coverage for air ambulance related to an Emergency Condition or air ambulance related to a non-Emergency Condition is provided to the nearest Facility, as described in (B) above, when your medical condition is such that transportation by land ambulance is not appropriate; and your

medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:

a. The point of pick-up is inaccessible by land vehicle; or
b. Great distances or other obstacles (e.g., heavy traffic) prevent your timely transfer to the nearest Hospital with appropriate facilities.

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

Out-of-Network. Out-of-Network Benefits for services other than air ambulance are covered at 80% of the Allowable Expense, after the in-network Deductible. Out-of-Network Benefits for air ambulance are covered at 60% of the Allowable Expense, after Deductible.

8. **Pre-Hospital Emergency Services and Transportation**. The Benefit Plan will provide coverage for services to evaluate and treat an "emergency condition" as that term is defined in the Emergency Care Section of this Booklet when such services are provided by an ambulance service certified under the New York Public Health Law (or the comparable law of the state where the service is provided). The Benefit Plan also will provide coverage for land ambulance transportation to a Hospital by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

A. Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

B. Serious impairment to such person's bodily functions;

C. Serious dysfunction of any bodily organ or part of such person; or

D. Serious disfigurement of such person.

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

Out-of-Network. Out-of-Network Benefits for services other than air ambulance are covered at 80% of the Allowable Expense, after the in-network Deductible. Out-of-Network Benefits for air ambulance are covered at 60% of the Allowable Expense, after Deductible.

9. **Alternative Benefits.** If you agree to participate and abide by Excellus BlueCross BlueShield's policies, in addition to benefits specified in this Booklet, the Benefit Plan may provide, outside the terms described in this Booklet, benefits for services, for up to a 60-day period, furnished by any Participating Provider pursuant to an alternative

treatment plan developed by Excellus BlueCross BlueShield for a Member whose condition would otherwise require hospitalization.

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

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

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

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

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

Corporate Managed Care
165 Court Street
Rochester, NY 14647

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

10. **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).

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

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

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

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

11. **Acupuncture.** The Benefit Plan will provide coverage for acupuncture services. Services must be rendered by a Professional Provider licensed to provide such services; and determined by the Medical Director to be Medically Necessary.

The Benefit Plan will pay for a maximum of 10 visits per Member, per Calendar Year. In-Network Benefits and Out-of-Network Benefits will both be counted toward the Calendar Year visit maximum described above.

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

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

12. **In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19.** Effective as of March 13, 2020, and during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), or until such other date determined to be appropriate by the Employer, the Benefit Plan will provide coverage for an in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such a test for members suspected of a COVID-19 infection, or suspected of having recovered from COVID-19 infection, that—

(a) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb–3);

(b) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

(c) is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID–19; or

(d) other tests that the Secretary determines appropriate in guidance.

and which have been determined to be medically appropriate for you by your attending provider. In addition to the above, the Benefit Plan will provide coverage for any items and services provided during an office visit (including telehealth), urgent care center visit, or emergency room visit that relates to the furnishing or administration of the test or

to the evaluation of the individual for purposes of determining the need for the test; and results in an order for or administration of such test. Such coverage will be provided when rendered by a Participating Provider or Non-Participating Provider and will not be subject to any cost-sharing (i.e. Coinsurance, Copayments or Deductibles), preauthorization requirements or any other medical management requirements. Other services that you may receive during such a visit that are not related to determining the need for a test or administration of a test, will be subject to the normal Plan cost-sharing, preauthorization and medical management requirements.

SECTION ELEVEN - EMERGENCY CARE

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

1. **Emergency Services.** The Benefit Plan provides coverage for Emergency Services or non-Emergency Services for the treatment of an Emergency Condition or a non-Emergency Condition in a Hospital.

   Coverage of Emergency Services or non-Emergency Services for treatment of your Emergency Condition or non-Emergency Condition will be provided regardless of whether the provider is a Participating Provider or Non-Participating Provider. However, the Benefit Plan will cover only those Emergency Services or non-Emergency Services and supplies that are Medically Necessary and, with respect to an Emergency Condition, are performed to treat or stabilize your condition in a Hospital.

2. **Hospital Emergency Department Visits.** In the event that you require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency department care does not require preauthorization.

   The Benefit Plan does not cover follow-up care or routine care provided in a Hospital emergency department.

   Facility:

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

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

   Professional Provider:

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

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

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

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

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

SECTION TWELVE - HUMAN ORGAN AND BONE MARROW TRANSPLANTS

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

1. **Prior Approval Required.** All organ transplants must be pre-approved by Excellus BlueCross BlueShield. See Section Three for the Benefit Plan's pre-approval procedures. You or your Professional Provider must call Excellus BlueCross BlueShield within one week prior to admission to seek approval. In the event of the availability of an organ for transplantation resulting in the necessity for an immediate admission for implantation, you must call Excellus BlueCross BlueShield within 24 hours after your admission or as soon thereafter as reasonably possible. The Benefit Plan will provide coverage for the amount specified above only if it is determined the care was Medically Necessary, even though you did not seek Excellus BlueCross BlueShield's prior approval. If it is determined that the services were not Medically Necessary, you will be responsible for paying the entire charge for the service.

2. **Care in Approved Transplant Centers.** Certain types of organ transplant procedures must be performed in In-Network transplant centers approved by Excellus BlueCross BlueShield for the specific transplant procedure being performed. The types of organ transplants which must be performed in an In-Network transplant center are bone marrow transplants, liver transplants, heart transplants, lung transplants, heart-lung transplants, kidney transplants, and kidney-pancreas transplants. You may contact Excellus BlueCross BlueShield at the number on your member ID card if you wish to obtain a list of approved transplant centers.

3. **No Coverage of Experimental Or Investigational Organ Transplants.** The Benefit Plan will not provide coverage for any benefits for an organ transplant that is determined to be experimental or investigational. Excellus BlueCross BlueShield maintains and revises from time to time a list of organ transplant procedures which it determines not to be experimental or investigational, and, therefore, may be covered under the Benefit Plan. You may contact Excellus BlueCross BlueShield at the number on your member ID card if you have a question concerning whether a particular transplant procedure may be covered.

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

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

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

SECTION THIRTEEN - PRESCRIPTION DRUGS

1. **Definitions.**

A. **Brand Name Drug**. A Prescription Drug that is manufactured and marketed under a trademark or name by a specific manufacturer.

B. **Generic Drug**. A Prescription Drug that is chemically equivalent to a Brand Name Drug whose patent has expired, and that meets Excellus BlueCross BlueShield's criteria for designation as a Generic Drug.

C. **Non-Participating Pharmacy**. Any pharmacy that dispenses Prescription Drugs and has not entered into a participation agreement with Excellus BlueCross BlueShield. **The Benefit Plan will not pay any benefits for Prescription Drugs you purchase at a Non-Participating Pharmacy.**

E. **Participating Pharmacy**. Any pharmacy that regularly dispenses Prescription Drugs and has entered into a participation agreement with Excellus BlueCross BlueShield.

F. **Prescription Drugs**. Drugs, biologicals, and compounded prescriptions that can be dispensed only pursuant to a prescription and that are required by law to bear the legend "Caution - Federal Law prohibits dispensing without a prescription", or that are specifically designated by Excellus BlueCross BlueShield. The drug or medication must be prescribed by a duly licensed provider, and approved by the FDA for the treatment of your specific diagnosis or condition. The drug must also be approved as Medically Necessary treatment of the condition for which the drug is prescribed. In certain situations, specific criteria, including Medical Necessity criteria, may be established by Excellus BlueCross BlueShield and its provider community, defining whether certain drugs will be covered under this Benefit Plan. However, if there is a drug that has been approved for the treatment of one type of cancer, the Benefit Plan will also pay for this drug for the treatment of other types of cancer, so long as the drug meets the requirements of New York Insurance Law Section 4303(q) as applicable to insured products.

Prescription Drugs shall include Medically Necessary enteral formulas for which a Participating Provider has issued a written order. The written order must state that the enteral formula is clearly Medically Necessary and has been proven effective as a disease-specific method of treatment for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated. The Benefit Plan will also pay for modified solid food products for the treatment of certain inherited diseases of amino acid or organic acid metabolism, when provided pursuant to such written order.

Prescription Drugs shall also include Medically Necessary *oral* infertility drugs that the FDA has approved specifically for the diagnosis and treatment of

infertility and that are prescribed or dispensed in connection with infertility treatment services, if any, covered under your medical benefit plan provided by the Group. Medically Necessary *injectable* infertility drugs that the FDA has approved specifically for the diagnosis and treatment of infertility and that are prescribed or dispensed in connection with infertility treatment services, if any, are covered under your medical benefit plan provided by the Group.

In addition, Prescription Drugs include prescription contraceptive drugs and devices, or their generic equivalents, approved by the federal food and drug administration. The drug or device must be prescribed by Professional Provider who is legally authorized to prescribe drugs. All of the limitations and restrictions, including any deductible, copayment, or coinsurance, that are applicable to your prescription drug benefit also apply to this benefit. The Benefit Plan will also cover contraceptive devices administered by a Professional Provider. These contraceptive devices include, but are not limited to: diaphragms; IUDs; contraceptive implants, such as Norplant; and contraceptive injections such as Depo-Provera. They are covered as a service of the Professional Provider who administers them. All of the limitations and restrictions, including any deductible, copayment, or coinsurance, that are applicable to your prescription drug benefit also apply to this benefit.

G. **Tier One Drug.** A Generic Prescription Drug that Excellus BlueCross BlueShield designates as a Tier One Drug.

H. **Tier Two Drug.** A Prescription Drug that is included on Excellus BlueCross BlueShield's Tier Two Drug list. Tier Two Drugs are selected for their effectiveness, utilization, and cost. The Tier Two Drug list is always under review and subject to update. A copy of the then current Tier Two Drug list can be obtained from Excellus BlueCross BlueShield upon request.

I. **Tier Three Drug.** A Prescription Drug that is not a Tier One Drug or a Tier Two Drug.

J. **"You", "Your", and "Yours"**. Throughout this Booklet, the words "you", "your" and "yours" refers to you, the employee or member of the Group to whom this Booklet is issued. If other than individual coverage applies, then, in most cases, the word "you" also includes any family members who are covered under this Benefit Plan.

2. **Pharmacy Benefits Provided**

A. **Drugs from a Retail Participating Pharmacy.** Once you have satisfied the Deductible, you will be required to pay the following:

(1) If you have a prescription filled with a Tier One Drug, you must pay the pharmacy a $5 Copayment (for a 30-day supply) for each separate prescription or refill for that Tier One Drug. The pharmacy will be paid

directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

(2) Tier Two Drug – If you have a prescription filled with a Tier Two Drug, you must pay the pharmacy a $35 Copayment (for a 30-day supply) for each separate prescription or refill for that Tier Two Drug. The pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

(3) Tier Three Drug – If you have a prescription filled with a Tier Three Drug, you must pay the pharmacy a $70 Copayment (for a 30-day supply) for each separate prescription or refill for that Tier Three Drug. The pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

B. **Drugs from a Participating Mail Service Pharmacy.** Once you have satisfied the Deductible, Prescription Drugs are available from a Participating mail service pharmacy as follows:

(1) If you have a prescription filled with a Tier One Drug, you must pay the pharmacy a $10 Copayment (for a 90-day supply) for each separate prescription or refill for that Tier One Drug. The pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

(2) Tier Two Drug – If you have a prescription filled with a Tier Two Drug, you must pay the pharmacy a $70 Copayment (for a 90-day supply) for each separate prescription or refill for that Tier Two Drug. The pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

(3) Tier Three Drug – If you have a prescription filled with a Tier Three Drug, you must pay the pharmacy a $140 Copayment (for a 90-day supply) for each separate prescription or refill for that Tier Three Drug. The pharmacy will be paid directly by the Benefit Plan for the remainder of the cost of the prescription or refill.

C. **Drugs from a Non-Participating Pharmacy.** The Benefit Plan will not pay any benefits for Prescription Drugs that you purchase at a Non-Participating Pharmacy.

D. **Emergency Supply of Prescription Drugs for Substance Use Disorder Treatment.** If you have an Emergency Condition (as defined below), you may immediately access, without preauthorization, a five (5) day emergency supply of a Prescription Drug for the treatment of a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for

opioid overdose reversal. If you have satisfied the Deductible your Copayment will be prorated. If you receive an additional supply of the Prescription Drug within the 30-day period in which you received the emergency supply, your Copayment for the remainder of the 30-day supply will also be prorated if you have already satisfied the Deductible. In no event will the prorated Copayment(s) total more than your Copayment for a 30-day supply.

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

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

E. **Initial Limited Supply of Prescription Opioid Drugs.** If you receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and once you have satisfied the Deductible, your Copayment will be prorated. If you receive an additional supply of the Prescription Drug within the 30-day period in which you received the seven (7) day supply, once you have satisfied the Deductible, your Copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated Copayment(s) total more than your Copayment for a 30-day supply.

3. **Limitations**

A. **Supply Limits.** Except for contraceptive drugs or devices, the Benefit Plan will pay for no more than a 30-day supply of a drug purchased at a retail Participating Pharmacy or a 90 day supply dispensed by a mail order Participating Pharmacy.

You may have an initial three-month supply of a contraceptive drug or device dispensed to you. For subsequent dispensing of the same contraceptive drug or device, you may have the entire prescribed supply (of up to 12 months) of the contraceptive drug or device dispensed at the same time. Contraceptive drugs and devices are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Pharmacy. For other contraceptive drugs and devices, for an initial three-month supply, once you have satisfied the Deductible, you are responsible for up to three (3) Copayment amounts at a

retail pharmacy or up to two (2) Copayments for contraceptive drugs and devices dispensed by a mail order pharmacy and you are responsible for up to nine (9) Copayments at a retail pharmacy or up to six (6) Copayment amounts for contraceptive drugs and devices dispensed by a mail order pharmacy for the remaining supply of a 12 month prescription. For a subsequent 12 month dispensing of the same contraceptive drug or device, once you have satisfied the Deductible, you are responsible for up to twelve (12) Copayments at a retail pharmacy or up to eight (8) Copayments for contraceptive drugs and devices dispensed by a mail order pharmacy.

B. Covered quantities, day supply, early refill access, and/or duration of therapy may be limited for certain medications based on acceptable medical standards and/or FDA recommended guidelines.

C. Benefits will be provided for drug refills. However, no benefit will be provided for a refill obtained before the date it is determined that you should have exhausted most of your current supply. Benefits for refills will not be provided beyond one year from the original prescription date.

D. Excellus BlueCross BlueShield may periodically identify over-the-counter non-prescription drugs that will be covered in place of the Prescription Drug equivalent. If an over-the-counter non-prescription drug will be covered in place of a Prescription Drug, Excellus BlueCross BlueShield will notify you in writing in advance and will specify whether the Copayment for the non-prescription drug will be based on the Tier One, Tier Two, or Tier Three Copayment. A list of over-the-counter drugs that will be covered in place of Prescription Drugs can be obtained from Excellus BlueCross BlueShield's office.

E. Compounded Prescription Drugs will be covered only when they contain at least one ingredient that is a covered legend Prescription Drug, are Medically Necessary, and are obtained from a Participating Pharmacy that is approved for compounding.

F. A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.

G. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. In the event a use management protocol is implemented, you will be notified in advance. The primary goal of the protocols is to provide a quality-focused drug benefit and/or to control rising costs. For example, for certain types of illnesses or conditions, such as high cholesterol, high blood pressure, depression, and heartburn can be treated by a variety of drugs at different price levels. In those instances, you are encouraged to first try generic or lower cost brand name drugs as an alternative to higher cost brand name drugs, and you will be required to obtain approval to utilize a higher cost brand drug if a generic or lower cost brand

drug is available. In the event you choose to utilize a higher cost brand name drug, you will be required to pay the difference between the cost of the generic or lower cost brand name drug and the higher cost brand name drug. Step therapy protocols may also be utilized. Step therapy is a type of use management program under which certain medications included in the program will not be covered until one or more therapeutically equivalent prerequisite or "first-line" medications have been tried first. If, however, we determine it is medically necessary for you to use a step therapy medication in the first instance, your physician can contact us to request coverage. We will notify both you and your physician of our coverage decision.

H. **Prescription Drugs Subject To Prior Authorization.** Certain Prescription Drugs will only be filled with prior authorization from the Claims Administrator. The Prescription Drugs that require prior authorization are identified based upon cost, patient safety, and possible use for purposes that are not Medically Necessary or appropriate. The Prescription Drugs that require prior authorization are included on the form entitled "Prescription Drugs Requiring Prior Authorization" that is given to you with this Benefit Plan. The Prescription Drugs that require prior authorization are also identified on the formulary that is available at www.excellusbcbs.com or that will be mailed to you upon request. You may request the formulary by calling the number shown on your ID card. The Prescription Drugs that require prior authorization may change below. You are encouraged to call the Claims Administrator or consult the formulary to determine if prior authorization is required for a specific drug so that you can avoid any benefit reduction that will apply if you fail to comply with the prior authorization requirement.

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

With respect to an urgent request for prior authorization, if the Benefit Plan has all information necessary to make a determination, a determination will be made and you (or your designee) and your Professional Provider will be notified, by telephone and in writing, within 72 hours of receipt of the request. If additional information is needed to make a determination, the Benefit Plan will request the information within 24 hours after receipt of your request. You or your provider will then have 48 hours to submit the information. A determination will be made and notice will be provided to you and your provider by telephone and in writing within 48 hours of the earlier of receipt of the additional information or the end of

the 48-hour period. A request is "urgent" if failing to receive the service it could seriously jeopardize your life or health or the ability to regain maximum function; or if your provider determines that receipt of the service is urgent.

J. **Your Right to Appeal.** If you (or your designee) or your Professional Provider disagrees with the Benefit Plan's determination, you may appeal by following the appeal procedures set forth in Section Eighteen of this Benefit Plan.

K. **Failure to Seek Authorization.** When you fail to seek a required prior authorization of a Prescription Drug and the drug is dispensed, you must pay the Participating Pharmacy the total cost of the drug. If you then submit a claim, and the Claims Administrator determines that the Prescription Drug is Medically Necessary, the Benefit Plan will pay only 50% of the amount it would otherwise have paid for the Prescription Drug. If the Claims Administrator determines that the Prescription Drug is not Medically Necessary, no benefits will be provided for the Prescription Drug and you will be responsible for the entire charge.

L. **Formulary Exception Process.** If a Prescription Drug is not on the formulary, you, your designee or your prescribing Professional Provider may request a formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under the standard or expedited formulary exception process, you may be entitled to an external appeal as outlined in the General Provisions section of this Benefit Plan. Visit www.excellusbcbs.com or call the number on your ID card to find out more about this process.

1. **Standard Review of a Formulary Exception.** The Benefit Plan will make a decision and notify you or your designee and the prescribing Professional Provider no later than 72 hours after receipt of your request. If the request is approved, the Benefit Plan will cover the Prescription Drug while you are taking the Prescription Drug, including any refills.

2. **Expedited Review of a Formulary Exception.** If you are suffering from a health condition that may seriously jeopardize your health, life or ability to regain maximum function or if you are undergoing a current course of treatment using a non-formulary Prescription Drug, you may request an expedited review of a formulary exception.

   The request should include a statement from your prescribing Professional Provider that harm could reasonably come to you if the requested drug is not provided within the timeframes for the standard formulary exception process. The Benefit Plan will make a decision and notify you or your designee and the prescribing Professional Provider no later than 24 hours after receipt of your request. If the Benefit Plan approves the request, the Benefit Plan will cover the Prescription Drug while you suffer from the health condition that may seriously jeopardize your health, life or ability

to regain maximum function or for the duration of your current course of treatment using the non- formulary Prescription Drug.

M. **Step Therapy**. Step therapy is a program that requires you to try one (1) or more types of Prescription Drugs before the Benefit Plan will cover another as Medically Necessary. A "step therapy protocol" means the policy, protocol or program that establishes the sequence in which the Benefit Plan will approve Prescription Drugs for your medical condition. When establishing a step therapy protocol, recognized evidence-based and peer reviewed clinical review criteria is used that also takes into account the needs of atypical patient populations and diagnoses. Certain Prescription Drugs are checked to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require preauthorization under the step therapy program are also included on the preauthorization drug list. If a step therapy protocol is applicable to your request for coverage of a Prescription Drug, you, your designee, or your Professional Provider can request a step therapy override determination as outlined below.

1. **Step Therapy Override Determinations.** You, your designee, or your Professional Provider may request a step therapy protocol override determination for coverage of a Prescription Drug selected by your Professional Provider. When reviewing for a step therapy protocol override determination, Excellus BlueCross BlueShield will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for you and your medical condition.

   (a) **Supporting Rationale and Documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a Professional Provider, demonstrating that:

   - The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to you;
   - The required Prescription Drug(s) is expected to be ineffective based on your known clinical history, condition, and Prescription Drug regimen;
   - You have tried the required Prescription Drug(s) while covered by the Benefit Plan or under your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
   - You are stable on a Prescription Drug(s) selected by your Professional Provider for your medical condition, provided

this does not prevent Excellus BlueCross BlueShield from requiring you to try an AB-rated generic equivalent; or

- The required Prescription Drug(s) is not in your best interest because it will likely cause a significant barrier to your adherence to or compliance with your plan of care, will likely worsen a comorbid condition, or will likely decrease your ability to achieve or maintain reasonable functional ability in performing daily activities.

(b) **Standard Review.** The Benefit Plan will make a step therapy protocol override determination and provide notification to you (or your designee) and where appropriate, your Professional Provider, within 72 hours of receipt of the supporting rationale and documentation.

(c) **Expedited Review.** If you have a medical condition that places your health in serious jeopardy without the Prescription Drug prescribed by your Professional Provider, the Benefit Plan will make a step therapy protocol override determination and provide notification to you (or your designee) and your Professional Provider within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, the Benefit Plan will request the information within 72 hours for preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or your Professional Provider will have 45 calendar days to submit the information for preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For preauthorization reviews, the Benefit Plan will make a determination and provide notification to you (or your designee) and your Professional Provider within the earlier of 72 hours of receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, the Benefit Plan will make a determination and provide notification to you (or your designee) and your Professional Provider within the earlier of 72 hours or one (1) business day of receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, the Benefit Plan will make a determination and provide notification to you (or your designee) and your Professional Provider within the earlier of 72 hours of receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, the Benefit Plan will make a determination and provide notification to you (or your designee) and your Professional Provider within the earlier of 24 hours of receipt of the

information or 48 hours of the end of the 48-hour period if the information is not received.

If the Benefit Plan does not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If the Benefit Plan determines that the step therapy protocol should be overridden, immediate coverage will be authorized for the Prescription Drug prescribed by your treating Professional Provider. An adverse step therapy override determination is eligible for an appeal pursuant to the General Provisions section of this Benefit Plan.

4. **Exclusions.** In addition to the exclusions specified elsewhere in this Booklet, the Benefit Plan will not provide coverage under this Section for the following:

A. Drugs that do not by law require a prescription, except as otherwise provided in this Section.

B. Prescription Drugs that have over-the-counter non-prescription equivalents, except as otherwise provided under Subparagraph 3(D) of this Section or otherwise considered a preventive service in accordance with Section Ten. Non-prescription equivalents are drugs available without a prescription that contain the same active ingredient as their prescription counterparts.

C. Devices of any type, even though a prescription may be required. This includes therapeutic devices, artificial appliances, hypodermic needles, or similar devices.

D. Vitamins, or any herbal product, except those that require a prescription by law.

E. Drugs that are prescribed or dispensed for cosmetic purposes and are not Medically Necessary. Examples of the kinds of drugs that are often determined to be not Medically Necessary include those prescribed or dispensed for hair growth or removing wrinkles.

F. Drugs that are prescribed for experimental or investigational use, and drugs that are only available to persons who participate in clinical research programs.

G. Prescription Drugs to replace those that may have been lost or stolen.

H. Drugs dispensed in unit-dose packaging when bulk packaging is available.

I. Drugs given or administered in a physician's office or in an inpatient or outpatient facility.

J. Administration or injection of any drugs.

K. Drugs dispensed to you while a patient in a Facility, except in those cases where the basis of payment by you or on your behalf to the Facility does not include services for drugs.

L. Your benefit for diabetic supplies and equipment is not provided under this Section. Diabetic supplies and equipment, including blood glucose monitors, insulin, test strips, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for controlling blood sugar, are included, along with the applicable Copayment, Deductible, and/or Coinsurance charges that are set forth in the medical section of this Booklet.

M. Fertility drugs relating to reversal of elective sterilizations, including vasectomies and tubal ligations; sex change procedures; cloning; and other procedures or categories of procedures excluded by statute as applicable to insured health benefit contracts.

5. **General Conditions**

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

B. Drug Utilization, Cost Management, and Rebates. Excellus BlueCross BlueShield conducts various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, the Group and its members benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the cost of your coverage. Excellus BlueCross BlueShield may, from time to time, also enter into agreements that result in it receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors, or others. Any rebates are based upon utilization of Prescription Drug products across all of Excellus BlueCross BlueShield's business and not solely on any one person's or one group's utilization of Prescription Drugs. Any rebates received by Excellus BlueCross BlueShield may or may not be applied, in whole or part, to reduce the cost of your coverage either through an adjustment to claims costs or as an adjustment to the administrative expenses charged to the Group. Instead, any such rebates may be retained by Excellus BlueCross BlueShield, at its discretion, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities, and increasing reserves for the protection of subscribers covered under its insured products. Rebates will not change or reduce the amount of any Copayments, Deductibles, or Coinsurance that are applicable under your Prescription Drug coverage.

C. Neither the Group nor Excellus BlueCross BlueShield will be liable for any claim, injury, demand, or judgment based on tort or other grounds (including warranty of merchantability), arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any Prescription Drug whether or not covered under this Benefit Plan.

D. Benefits may be denied for any Prescription Drug prescribed or dispensed in a manner contrary to normal medical practice.

SECTION FOURTEEN - EXCLUSIONS

In addition to the exclusions and limitations described in other Sections of this Booklet, the 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, but are not limited to, the following: breast reduction or enlargement, rhinoplasty, and hair transplants. The Benefit Plan will, however, provide coverage for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other disease of the part of the body involved. The Benefit Plan also will provide coverage for reconstructive surgery because of congenital disease or anomaly of a child covered under this Benefit Plan that has resulted in a functional defect. The Benefit Plan also will provide coverage for services in connection with reconstructive surgery following a mastectomy, as provided in Section Nine.

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 this Benefit Plan in the absence of a court order;

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

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

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

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. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of your medical condition (including both physical and mental health conditions).

6. **Custodial Care.** The Benefit Plan will not provide coverage for any service or care that is custodial in nature, or any therapy that is reasonably determined to not be expected to improve your condition. Care is considered custodial when it is primarily for the purpose of meeting personal needs and includes activities of daily living such as help in transferring, bathing, dressing, eating, toileting, and such other related activities.

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 reason(s) that the service or care is necessary. For example, the Benefit Plan will not provide coverage for x-rays, fillings, extractions, braces, prosthetics, correction of impactions, treatments for gum disease, therapy, or other treatments related to dental oral surgery. The Benefit Plan will, however, provide coverage for medical treatment that is directly related to an injury or accident involving the jaw or other bone structures adjoining the teeth, provided that the treatment is approved by the Medical Director. The Benefit Plan will provide the benefits set forth in this Booklet for service and care for treatment of sound natural teeth provided within twelve (12) months of an accidental injury. The 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 the benefits set forth in this Booklet for service and care that Excellus BlueCross BlueShield determines in its sole judgment is Medically Necessary for treatment due to a congenital disease or anomaly. For purposes of this paragraph, "congenital" means the disease or anomaly is present and its symptoms or characterizations are evident and observable at birth. The Benefit Plan will also cover services for treatment of medical TMJ following diagnosis of medical TMJ. The Benefit Plan will not provide coverage for the treatment of dental TMJ. The Benefit Plan will also provide coverage for services that Excellus BlueCross BlueShield determines in its sole judgment are Medically Necessary for the treatment of cleft palate and ectodermal dysplasia. The Benefit Plan will cover institutional provider services for dental care when Excellus BlueCross BlueShield determines there is an underlying medical condition requiring these services. Covered services will be covered in the same manner as similar services. For example, a covered office visit will be covered the same as a medical office visit and a Medically Necessary and covered crown will be covered as an external prosthetic.

8. **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.

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

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

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

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

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

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

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

A. A Service that is a medical device, drug, or biological product must have received final approval of the United States Food and Drug Administration (FDA) to market for the particular diagnosis or for your particular condition. Any other

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

B. Published, peer-reviewed, medical literature must provide conclusive evidence that the Service has a definite, positive effect on health outcomes. The evidence must include reports of well-designed investigations that have been reproduced by nonaffiliated, authoritative sources with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

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

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

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

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

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

11. **Government Hospitals**. Except as otherwise required by law, the Benefit Plan will not provide coverage for any service or care you receive in a Facility or institution which is owned, operated or maintained by the Veterans Administration, or by a federal, state, or local government, unless the Facility is a Participating Provider. However, the Benefit

Plan will provide coverage for services or care in such a Facility to treat an Emergency Condition. In this case, the Benefit Plan will continue to provide coverage only for as long as emergency care is necessary and it is not possible for you to be transferred to another Facility.

12. **Government Programs.** The Benefit Plan will not provide coverage for any service or care for which benefits are payable under Medicare or any other federal, state, or local government program, except when required by state or federal law. When you are eligible for Medicare, the Benefit Plan will reduce our benefits by the amount Medicare would have paid for the services. Except as otherwise required by law, this reduction is made even if: you fail to enroll in Medicare; you do not pay the charges for Medicare; or you receive services at a Facility that cannot bill Medicare.

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

A. **Eligibility for Medicare By Reason of Age.** You are entitled to benefits under Medicare by reason of your age, and the following conditions are met:

(1) The employee or member of the Group is in "current employment status" (working actively and not retired) with the Group; and

(2) The Group maintains or participates in an employer group health plan that is required by law to have this Benefit Plan pay its benefits before Medicare.

B. **Eligibility for Medicare By Reason of Disability Other than End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of disability (other than end-stage renal disease), and the following conditions are met:

(1) The employee or member of the Group is in "current employment status" (working actively and not retired) with the Group; and

(2) The Group maintains or participates in a large group health plan, as defined by law, that is required by law to have this Benefit Plan pay its benefits before Medicare pays.

C. **Eligibility for Medicare By Reason of End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. The Benefit Plan will not reduce this Benefit Plan's benefits, and the Benefit Plan will provide benefits before Medicare pays, during the waiting period. The Benefit Plan will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before benefits are provided under this Benefit Plan.

13. **Military Service-Connected Conditions.** The Benefit Plan will not provide coverage for any service or care related to any military service-connected disability or condition, if the Veterans Administration has the responsibility to provide the service or care.

14. **No-Fault Automobile Insurance.** The Benefit Plan will not provide coverage for any service or care for which benefits are available under mandatory no-fault automobile insurance, until you have used up all of the benefits of the mandatory no-fault policy. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy. Benefits will be provided for services covered under this Benefit Plan when you have exceeded the maximum benefits of the no-fault policy. Should you be denied benefits under the no-fault policy because it has a Deductible, the Benefit Plan will provide coverage for the services covered under this Benefit Plan, up to the amount of the Deductible. The Benefit Plan will not provide benefits even if you bring a lawsuit against the person who caused your injury and even if you receive money from that lawsuit and you have repaid the medical expenses for which you received payment for under the mandatory automobile no-fault coverage.

15. **Non-Covered Service.** The Benefit Plan will not provide coverage for any service or care that is not specifically described in this Booklet as a covered service; or that is related to service or care not covered under this Benefit Plan; even when a Participating Provider considers the service or care to be Medically Necessary and appropriate.

16. **Nutritional Therapy.** The Benefit Plan will not provide coverage for any service or care related to nutritional therapy, unless it is determined that it is Medically Necessary or that it qualifies as diabetes self-management education or is otherwise required to be covered by law. The Benefit Plan will not provide coverage for commercial weight loss programs or other programs with dietary supplements.

17. **Personal Comfort Services.** The Benefit Plan will not provide coverage for any service or care that is for personal comfort or for uses not primarily medical in nature, including, but not limited to: radios, telephones, televisions, air conditioners, humidifiers, dehumidifiers, and air purifiers; beauty and barber services; commodes; and exercise equipment or orthotics used solely for sports.

18. **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.

19. **Reproductive Procedures.** The Benefit Plan will not provide coverage for any service or care related to or in connection with: in-vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cloning, sperm banking and donor fees associated with artificial insemination or other procedures, or other procedures or categories of procedures excluded by statute as applicable to insured health benefits contracts.

20. **Reversal of Elective Sterilization.** The Benefit Plan will not provide coverage for any service or care related to the reversal of elective sterilization, unless Medically Necessary.

21. **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.

22. **School System Services.** The Benefit Plan will not provide coverage for any covered services that are available under or covered or provided by an individualized education plan (IEP) or an early intervention program (EIP) or any similar program that is mandated by law or that any school system or state or local government is required to provide under any law; this applies even if the Member, parent or guardian does not seek such services under an available program or plan. This exclusion does not apply to otherwise covered services that exceed the recommendations of or which are not available through the IEP, EIP or other program.

23. **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.

24. **Services Covered under Hospice Care**. If you have been formally admitted to a hospice program and the Benefit Plan is providing coverage for your hospice care, the Benefit Plan will not provide additional coverage for any services related to your terminal illness that have been or should be included in the payment to the hospice program for the care you receive. However, should you require services covered under this Benefit Plan for a condition not covered under the hospice program, coverage will be available under this Benefit Plan for those covered services.

25. **Special Charges.** The Benefit Plan will not provide coverage for charges billed to you for telephone consultations (except telemedicine and telehealth services covered in accordance with the Excellus BlueCross BlueShield telemedicine and telehealth medical policy), missed appointments, new patient processing, interest, copies of provider records, or completion of claims forms. This exclusion applies to any late charges or extra day charges that you incur upon discharge from a Facility, because you did not leave the Facility before the Facility's discharge time.

26. **Social Counseling and Therapy.** The Benefit Plan will not provide coverage for any service or care related to family, marital, religious, or other social counseling or therapy, except as otherwise explicitly provided in this Booklet.

27. **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.

28. **Vision and Hearing Therapies and Supplies.** The Benefit Plan will not provide coverage for any service or care related to hearing aids for Members over age 19, vision or hearing therapy, eyewear (except for the initial prescription for contact lenses or lenses and frames following cataract surgery), vision training, or orthoptics.

29. **Weight Loss Services.** Except to the extent required by law, the Benefit Plan will not provide coverage for any service or care in connection with weight reduction or dietary control, including, but not limited to, gastric stapling, gastric by-pass, gastric bubble, other surgery that is determined to be medically inappropriate for treatment of obesity, or weight loss programs. The Benefit Plan, however, will provide benefits for covered services related to Medically Necessary treatment of morbid obesity, where weight is at least twice the ideal amount specified for frame, age, height, and gender in the most recent generally-accepted life insurance tables.

30. **Workers' Compensation.** The Benefit Plan will not provide coverage for any service or care for which benefits are available to you under a workers' compensation or similar law. The Benefit Plan will not provide coverage for the service or care even if you do not receive the benefits available, under the law because a proper or timely claim for the benefits was not submitted; or you fail to appear at a workers' compensation hearing. The Benefit Plan will not provide coverage even if you bring a lawsuit against the person who caused your injury or condition and even if you receive money from that lawsuit and you have repaid the medical expenses for which you received payment under a workers' compensation law or similar legislation.

SECTION FIFTEEN - COORDINATION OF BENEFITS

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

A. **When You Have Other Health Benefits.** It is not unusual to find yourself covered by two health insurance contracts, plans, or policies ("plans") providing similar benefits both issued through or to groups. When that is the case and you receive an item of service that would be covered by both plans, the Benefit Plan will coordinate benefit payments with any payment made under the other plan. Coordination of Benefits (COB) takes effect when a subscriber and their dependents have insurance other than this Benefit Plan. The general rule the Benefit Plan follows is that the subscriber and spouse or domestic partner are primary under their own respective contract. One plan will pay its full benefit as the primary plan. The other plan will pay secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance plan:

i. Any group or blanket insurance contract, plan, or policy, including HMO and other prepaid group coverage, except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan, or policy;

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

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

iv. Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and

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

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

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

ii. If you are covered under one plan as an employee, subscriber, or member and you are only covered as a dependent under the other plan, the plan which covers you as an employee, subscriber, or member will be primary; or

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

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

1. If the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.

2. If no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:

   a. First, the plan of the parent with custody of the child;

   b. Then, the plan of the spouse or domestic partner of the parent with custody of the child;

   c. Finally, the plan of the parent not having custody of the child.

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

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

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

This Benefit Plan uses a Coordination of Benefits (COB) methodology. The intent of COB is to pay benefits that will not exceed the normal level of benefits that would have been payable under the plan with the highest benefits.

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

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

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

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

D. **Right to Receive and Release Necessary Information.** The Group and Excellus BlueCross BlueShield have the right to release or obtain information which they believe necessary to carry out the purpose of this Section. They need not tell you or obtain anyone's consent to do this except as required by Article 25 of the New York General Business Law or the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). Neither the Group nor Excellus BlueCross BlueShield will be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information that is requested. If you do not furnish the information, payments may be denied.

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

F. **The Benefit Plan's Right to Recover Overpayment.** In some cases, the Benefit Plan may have made payment even though you had coverage under another plan. Under these circumstances, you must refund to the Group or the Benefit Plan the amount by which the Benefit Plan should have reduced its payment. The Group or the Benefit Plan also have the right to recover the overpayment from the other health benefits plan if they have not already received payment from that other plan. You must sign any document which is necessary to help the Benefit Plan recover any overpayment.

SECTION SIXTEEN - TERMINATION OF YOUR COVERAGE

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

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

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

1. You choose to terminate your coverage. You must give the Group thirty (30) days' written notice. Your coverage will terminate on the date to which your contributions are paid;

2. You are no longer a Member of the Group. Your coverage will terminate on the date to which your contributions are paid if you are no longer a Member of the Group;

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

4. Termination of the employee of the Group's marriage or domestic partnership. If the employee of the Group becomes divorced, or the employee of the Group's marriage is annulled, or if the domestic partnership of an employee of the Group terminates, coverage of the employee of the Group's spouse or domestic partner under this Benefit Plan will automatically terminate on the date of the divorce or annulment or termination of domestic partnership; or

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

C. **Temporary Continuation of Coverage.** Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. 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 a Participating 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 a Non-Participating Provider, payment may be made to either you or the provider at the option of the Group or the Claims Administrator.

5. **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.

6. **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.

7. **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.

8. **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.

9. **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.

10. **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.

11. **Who May Change this Benefit Plan.** The Benefit Plan may not be modified; amended; or changed, except in writing, and signed by the Chief Operating Officer ("COO") of the Group or a person duly authorized in writing by the COO of the Group to make changes to this Benefit Plan. No employee; agent; or other person is authorized to interpret; amend; modify; or otherwise change the Benefit Plan in a manner that expands or limits the scope of coverage; or the conditions of eligibility; enrollment; or participation, unless in writing and signed by the COO of the Group or by a person duly authorized in writing by the COO of the Group.

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

13. **Agreements between the Claims Administrator and Participating Providers.** Any agreement between the Claims Administrator and Participating 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 Participating Provider or any health benefits program.

14. **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.

15. **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.

16. **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.

17. **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.

18. **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 Members, 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.

19. **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.

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

21. **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.

22. **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 "Participating 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 Non-Participating 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 Participating 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 Non-Participating 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 Non-Participating 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 Non-Participating 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.

23. **Claim and Appeal Procedures.** You or your provider must submit a claim form before reimbursement for an eligible expense can be paid. Claim forms are available from the Group or the Claims Administrator.

When submitting a claim form, include:

(1) The name of the patient;
(2) The name, address, telephone number and tax identification number of the provider;
(3) The name of the employee;
(4) The place where the services were rendered;
(5) The diagnosis and procedure codes;
(6) The amount of charges;
(7) The name of the Benefit Plan; and
(8) The date of service.

Payments will be made directly to Participating Providers. Payments for services rendered by a Non-Participating Provider may be payable directly to the Non-Participating Provider or the Member. Submit claim forms to:

For Medical Claims:

Excellus Health Plan, Inc.
P.O. Box 21146
Eagan, MN 55121

For Prescription Drug Claims:

Express Scripts
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711
Fax: 608-741-5475

Timely Claim Filing Requirement
All claims must be filed with the Benefit Plan within 12 months after you receive the services for which payment is being requested. Claims filed after this time period will be denied.

Procedures for all Claims
The Benefit Plan's claim procedures are intended to reflect the U.S. Department of Labor's claims procedure regulations and should be interpreted accordingly. In the event of any conflict between this Benefit Plan and those regulations, those regulations will control. In addition, any changes in those regulations shall be deemed to amend this Benefit Plan automatically, effective as of the date of those changes.

To receive benefits under the Benefit Plan, you or your authorized representative must follow the procedures outlined in this section. There are four (4) different types of claims: (1) Post-service claims; (2) Pre-service claims; (3) Concurrent care claims; and (4) Urgent care claims.

Post-Service Claims
Post-service claims are those claims that are filed for payment of benefits after health care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. This 30-day period may be extended by the Claims Administrator for up to 15 days. In addition, the Claims Administrator will notify you within the initial 30-day period if additional information is required to process the claim, and will put your claim on hold until all information is received.

Once notified of the extension and the additional information required to process the claim, you have 45 days to provide the required information. If all of the required information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims
Pre-service claims are those claims that require notification or approval prior to receiving health care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision (whether or not adverse) from the Claims Administrator within 15 days of receipt of the claim.

If the Claims Administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision shall be furnished to you prior to the end of the initial 15-day period. Such an extension generally will not exceed 15 days. However, if the extension is necessary because of your failure to provide required information you shall have 45 days to provide the information.

If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Urgent Care Claims
Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations:

You will receive notice of the benefit determination (whether or not adverse) in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.

However, if your urgent care claim is missing required information, the Claims Administrator will notify you of the omission and how to correct it within 24 hours after the urgent care claim was received. You will then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after the earlier of:

(1) The Claims Administrator's receipt of the requested information; or

(2) The end of the 48-hour period within which you were to provide the additional information requested.

Concurrent Care Claims
If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined above, your request will be decided by the Claims Administrator within 24 hours of the receipt of your request, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the time frames described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service time frames, whichever applies.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Claims Administrator reduces or terminates such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the Claims Administrator shall notify you (sufficiently in advance of the termination or reduction to appeal the decision and obtain a determination upon review of the decision) before the course of treatment is reduced or terminated.

Notice of Adverse Benefit Determination
If a claim is wholly or partially denied, or if a rescission of coverage occurs, the Claims Administrator will furnish the Benefit Plan participant with a written notice of the adverse benefit determination. The written notice will contain the following information:

(1) the specific reason or reasons for the adverse benefit determination;

(2) specific reference to those Benefit Plan provisions on which the adverse benefit determination is based;

(3) a description of any additional information or material necessary to complete the claim and an explanation of why such material or information is necessary;

(4) notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;

(5) A statement describing your right to request an external review (if applicable), or if applicable, to bring an action under ERISA Section 502(a);

(6) In the case of an adverse benefit determination by the Benefit Plan:

(a) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either (1) the specific rule, guideline, protocol, or other similar criterion; or (2) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request;

(b) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Benefit Plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.

(7) In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

(8) In the case of an adverse benefit determination, the Benefit Plan must:

(a) Ensure that any notice of adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and provide notice of the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(b) Ensure that the reason or reasons for the adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Benefit Plan's standard, if any, that was used in denying the claim;

(c) Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

(d) Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

Appealing a Denied Claim

If you disagree with a claim determination after following the above steps, you can contact Claims Administrator in writing to formally request an appeal. In your appeal, you may submit written comments, documents, records, and other information relating to

your claim for benefits. You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

The review of your claims shall take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a claim for benefits under a group health plan, the Benefit Plan will identify, upon request to the Claims Administrator, any medical experts whose advice was obtained on behalf of the Benefit Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

If the appeal relates to a claim for payment, your request should include:

(1) The patient's name and the identification number from the ID card,

(2) The date(s) of service(s),

(3) The provider's name,

(4) The reason you believe the claim should be paid, and

(5) Any documentation or other written information to support your request for claim payment.

You may appeal any denial of a claim within 180 days of receipt of such a denial by submitting a written request for review to the Claims Administrator at the following address:

Excellus Health Plan, Inc.
P.O. Box 4717
Syracuse, NY 13221.
Fax Number: 1-315-671-6656

The review of your appeal shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Benefit Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Benefit Plan will provide the claimant (i.e. you and your covered dependents), free of charge, with any new or additional evidence considered, relied upon, or generated by the Benefit Plan (or at the direction of the Benefit Plan) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give the claimant a reasonable opportunity to respond prior to that date.

Before the Benefit Plan can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give the claimant a reasonable opportunity to respond prior to that date.

In the case of a claim involving urgent care, you are entitled to an expedited review process pursuant to which:

(1) You may submit a request for an expedited appeal of an adverse benefit determination orally or in writing; and

(2) All necessary information, including the Benefit Plan's benefit determination on review, shall be transmitted between you and the Benefit Plan by telephone, facsimile, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review
For purposes of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a period of time is extended as permitted below due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be counted from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Appeal Process
A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Your participation in the Benefit Plan includes your consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal Determinations

(1) **Pre-Service and Post-Service Claim Appeals**
You will be provided with written notification of the decision on your appeal as follows:

(a) For appeals of pre-service claims (as defined above), your appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim.

(b) For appeals of post-service claims (as defined above), your appeal will be conducted and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

(2) **Urgent Claim Appeals**
Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

Manner of Notification of Final Internal Adverse Benefit Determination
The Claims Administrator shall provide a participant with written notification of the Benefit Plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the participant:

(1) The specific reason or reasons for the adverse benefit determination;

(2) Reference to the specific Benefit Plan provisions on which the adverse benefit determination is based;

(3) A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;

(4) A statement describing any voluntary appeal procedures offered by the Benefit Plan and the participant's right to obtain information about such procedures;

(5) A statement of the participant's right to bring an action under Section 502(a) of ERISA; and

(6) The following information:

(a) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either (1) the specific rule, guideline, protocol, or other similar criterion; or (2) a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the participant upon request;

(b) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Benefit Plan to the participant's medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request; and

(c) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(7) In the case of an adverse benefit determination the Benefit Plan must:

(a) Ensure that any notice of final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(b) Ensure that the reason or reasons for the final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim. This description must also include a discussion of the decision;

(c) Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

(d) Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

Adverse Benefit Determination
For purposes of the Benefit Plan's claim procedures, an "adverse benefit determination" is a denial, reduction or termination of, or a failure to provide or make payment (in whole, or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Benefit Plan and including a denial, reduction of termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined be experimental and/or investigation or not medically necessary or appropriate. Adverse benefit determination also includes a rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

External Review
You have the right to an "external review" of certain coverage determinations made by the Claims Administrator. An external review 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 review only if the requested service is Covered by the Benefit Plan.

You may have the right to an expedited external review if the timeframe for completion of an expedited internal appeal or a standard external review 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 review 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 review. The timeframes for determining expedited external reviews are shorter than the timeframes for standard external reviews.

> **Coverage Determinations Subject to External Review.** This subparagraph describes the general conditions for external review.
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> In general, you may not request an external review unless the Claims Administrator has issued a "final adverse determination" of your request for coverage through the internal appeal process. However, if you qualify for an expedited external review, you may also file an expedited external review at the same time as filing an expedited internal appeal. You are also eligible for an external review if both parties have agreed to an external review even though you have not obtained a final adverse determination.

To be eligible for external review, 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 review of any other determinations, even if those other determinations affect your coverage.

Requesting an External Review. If you meet the conditions described above, you or your authorized representative may request an external review by completing and filing a self-insured external review request form with the Claims Administrator. The Claims Administrator will send the external review 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 review.

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

Upon receipt of a request for an external review, 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.

Effect of External Review Determination
A determination on external review is binding on the Benefit Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Benefit Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Benefit Plan to provide benefits or payment on a claim, the Benefit Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Benefit Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

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

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 Plan. In addition, no legal action may be commenced or maintained to recover benefits under the Benefit Plan more than three (3) years after the date you received the service for which you want the Benefit Plan to pay.

Appointment of Authorized Representative
An authorized representative is a person you authorize, in writing, to act on your behalf with respect to a benefit claim and/or appeal a denial of benefits. It also means a person authorized by a court order to submit a benefit claim and/or appeal a denial of benefits on your behalf. An assignment of benefits by you to a provider will not constitute appointment of that provider as your authorized representative. To appoint an authorized representative, you must complete a form that can be obtained from the Benefit Plan Administrator or the Claims Administrator. However, for a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative without completion of this form.

24. **Temporary Tolling of Certain Timeframes.**

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

(a) request mid-year enrollment in medical coverage due to a HIPAA special enrollment event where the special enrollment period otherwise would include any day of the Outbreak Period;
(b) elect to initially enroll in COBRA continuation coverage if the 60-day initial election period otherwise would include any day of the Outbreak Period;
(c) make an initial or any subsequent COBRA premium payment if the time period (or the grace period) for making the COBRA premium payment otherwise would include any day of the Outbreak Period;
(d) provide a required notice to the Benefit Plan of a COBRA qualifying event, if the time period for providing the notice otherwise would include any day of the Outbreak Period;
(e) file an initial claim for benefits under the Benefit Plan if the timely filing period otherwise would include any day of the Outbreak Period;
(f) file an internal or external appeal (if applicable) in response to an adverse benefit determination if the time period for filing an internal or external appeal otherwise would include any day of the Outbreak Period; or
(g) perfect a request for external review (if applicable) in response to a notice that the request is not complete if the time period for perfecting the request otherwise would include any day of the Outbreak Period.

In all cases where a time period referred to in (a)-(g) above began before March 1, 2020, in determining the extended time period based on the above rule, any period of time prior

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

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

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

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

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