

Member Contract and Other Legal Information



A nonprofit independent licensee of the BlueCross BlueShield Association

Dear Subscriber:

Welcome to Excellus BlueCross BlueShield.

This document contains your Member Certificate or Contract. We encourage you to read this document in its entirety. Please note that Riders, Endorsements or Disclosures that modify certain benefits and exclusions in the Member Certificate or Contract are located in the back of the document.

This is an important legal document. Please keep it in a safe place.

If you have any questions, please contact us at the telephone number on your identification card or visit us at www.excellusbcbcs.com.

Customer Service
Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647



This is your
BASIC HOSPITAL CERTIFICATE OF COVERAGE

Issued by
EXCELLUS HEALTH PLAN, INC.
A nonprofit independent licensee of the BlueCross BlueShield Association

This Certificate of Coverage ("Certificate") explains the benefits available to you under a Group Contract between Excellus Health Plan, Inc. (hereinafter referred to as "we", "us", "our", or "the Plan") and the group contract holder listed in the Group Contract. This Certificate is not a contract between you and us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer

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SECTION ONE — INTRODUCTION AND DEFINITIONS

1. **Your Coverage Under This Certificate.** Your employer or organization (referred to as the "group contract holder") has purchased a group health insurance contract from us. Under that contract we will provide the benefits described in this Certificate to members of the group, that is, to employees of the employer or to members of the organization and their covered dependents. However, this Certificate is not a contract between you and us. You should keep this Certificate with your other important papers so that it is available for your future reference.
2. **Definitions.**
 - A. **Allowable Expense.** "Allowable Expense" means the maximum amount we will pay to a Facility for the services or supplies covered under this Certificate, before any applicable Copayment amounts are subtracted. We determine our Allowable Expense as follows:
 - (1) The Allowable Expense for covered services received from a Facility is the amount set by state or federal law. In the absence of state or federal law, the Allowable Expense for Participating Providers will be the amount we have negotiated with the Facility or the amount approved by another Blue Cross and Blue Shield Plan; and the Allowable Expense for Non-Participating Providers will be 80% of the provider's charge.
 - (2) The Allowable Expense for services rendered by Non-Participating Providers in connection with an Emergency Condition is the provider's charge.
 - B. **Biologically-Based Mental Illness.** A mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Biologically-based mental illnesses are defined as the following:
 - (1) Schizophrenia/psychotic disorders;
 - (2) Major depression;
 - (3) Bipolar disorder;
 - (4) Delusional disorders;
 - (5) Panic disorder;
 - (6) Obsessive compulsive disorder;
 - (7) Bulimia; and
 - (8) Anorexia.
 - C. **Calendar Year.** The 12-month period beginning on January 1 and ending on December 31. However, if you were not covered under this Certificate for this entire period, Calendar Year means the period from the date you became covered until December 31.
 - D. **Children with Serious Emotional Disturbances.** Persons under the age of 18 years who have diagnoses of attention deficit disorders, disruptive behavior disorders or pervasive development disorders, and where one or more of the following are present:
 - (1) Serious suicidal symptoms or other life-threatening self-destructive behaviors;
 - (2) Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
 - (3) Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or
 - (4) Behavior caused by emotional disturbances that placed the child at significant risk of removal from the household.

- E. **Copayment.** A charge, expressed as a fixed dollar amount, that you must pay for certain health services covered under this Certificate. You are responsible for the payment of any Copayments directly to Participating Providers when you receive health services.
- F. **Effective Date.** The date your coverage under this Certificate begins. Coverage begins at 12:01 a.m. on the Effective Date.
- G. **Emergency Condition.** A medical or behavioral condition, the onset of which is sudden and that manifests itself by symptoms of sufficient severity, including 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:
 - (1) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or
 - (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 we consider to be Emergency Conditions are heart attacks, poisoning and multiple trauma.

Examples of conditions we do not ordinarily consider to be Emergency Conditions are head colds, flu, minor cuts and bruises, muscle strain and hemorrhoids.

- H. **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; an institutional provider of mental health or chemical dependence and abuse treatment operating under Article 31 of the New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or other provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable). If you receive treatment for chemical dependence or abuse outside of New York State, the Facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") to provide a chemical abuse treatment program.
- I. **Hospital.** Any short-term acute general hospital facility that is accredited as a hospital by JCAHO; is certified under Medicare; and if located in New York State, is licensed pursuant to Article 28 of the Public Health Law of New York. A Hospital is a licensed institution primarily engaged in providing:
 - (1) Inpatient diagnostic and therapeutic services for surgical and medical diagnosis;
 - (2) Treatment and care of injured and sick persons by or under the supervision of physicians; and
 - (3) Twenty-four (24) hour nursing service by or under the supervision of registered nurses.

None of the following are considered Hospitals:

- (1) Hospitals for treatment of mental illness. If you are a patient in a separate division or unit of a Hospital dedicated to the treatment of mental illness where the average length of stay is more than 30 days, that separate division or unit is not considered a Hospital;
- (2) Places primarily for nursing care;
- (3) Skilled Nursing Facilities;
- (4) Convalescent homes or similar institutions;
- (5) Institutions primarily for: custodial care; rest; or as domiciles;
- (6) Health resorts; spas; or sanitariums;

- (7) Infirmaries at schools; colleges; or camps;
 - (8) Places primarily for the treatment of chemical dependence and abuse; hospice care; or rehabilitation;
 - (9) Free standing ambulatory surgical centers.
- J. **Medical Director.** The person designated by us to monitor quality of care and appropriate utilization of health services.
- K. **Medical Necessity.** See Section Three.
- L. **Mental Illness.** A mental, nervous or emotional condition that we determine has treatable behavioral manifestations and that we also determine:
- (1) Is a clinically significant alteration in thinking, mood or behavior, or a combination thereof; and
 - (2) Substantially or materially impairs your ability to function in one or more major life activities; and
 - (3) Has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
- M. **Member.** Any Subscriber or eligible dependent who meets all applicable eligibility requirements, for whom the required premium payment has actually been received by us, and who is covered under this Certificate.
- N. **Non-Participating Provider.** A Facility or Professional Provider that does not have a provider agreement with us or any other Blue Cross and/or Blue Shield Plan to provide health services to Members.
- O. **Participating Provider.** A Facility or Professional Provider that has a provider agreement with us or any other Blue Cross and/or Blue Shield Plan to provide health services to Members. We have provider directories that list all of our Participating Providers. Copies of the directory are issued on enrollment and are available free of charge upon request.
- P. **Professional Provider.** A certified and licensed physician; osteopath; dentist; optometrist; chiropractor; registered psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; licensed midwife; speech-language pathologist; audiologist; or any other licensed health care provider that the New York State Insurance Law requires to be recognized who charges and bills patients for services.
- Q. **Service Area.** The geographic area in which we provide benefits to our Members. Our Service Area consists of the following counties: Monroe; Wayne; Livingston; Seneca; Yates; and Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson.
- R. **Skilled Care.** A service that we determine 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.
- S. **Skilled Nursing Facility.** A facility accredited as a Skilled Nursing Facility by JCAHO or qualified as a Skilled Nursing Facility under Medicare. We will provide coverage for your care in a Skilled Nursing Facility under a Rider to this Certificate only if we determine that the care is Skilled Care.
- T. **Subscriber.** The member of the group to whom this Certificate is issued.

- U. **"We", "Us", "Our" or "The Plan" and "You", "Your" and "Yours"**. Throughout this Certificate, Excellus Health Plan, Inc. will be referred to as "we", "us", "our" or "the Plan". The word "you", "your" or "yours" refers to you, the Subscriber. If other than individual coverage applies, then in most cases the word "you" also includes any family members who are covered under this Certificate.

SECTION TWO — WHO IS COVERED

1. **Who Is Covered Under This Certificate.** Subject to the permissible eligibility rules of the group contract holder, you, the Subscriber to whom this Certificate is issued, are covered under this Certificate. If you selected other than individual coverage, the following members of your family may also be covered:
- A. Your spouse, unless you are divorced or your marriage has been annulled.
 - B. Your unmarried children who are under 19 years of age and who are chiefly dependent on you for support.
 - C. Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age at which the child's coverage under this Certificate would otherwise have terminated. The child's disability must be certified by a physician. You must file an application in the form we approve to request that the child be included in your family coverage. We have the right to check whether a child is and continues to qualify under this paragraph. (See Section Fourteen for when coverage terminates.)

We have the right to request, and have furnished to us, such proof as may be needed to determine eligibility status of a prospective Subscriber and all prospective dependents as they pertain to eligibility for coverage under this Certificate.

2. **Other Children Covered Under This Certificate.** In addition to your natural children, the following other children may also be covered under this Certificate if the child meets the above eligibility requirements for children covered under this Certificate:
- A. A legally adopted child;
 - B. A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order;
 - C. A stepchild who is chiefly dependent upon you for support; and
 - D. A child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption becoming final.

We have the right to request, and have furnished to us, such proof as may be needed to determine whether a child qualifies as a dependent for purposes of coverage under this Certificate.

3. **Newborn Child.** If you have a type of coverage that would cover a newborn, your newborn child will be covered at birth, provided you notify us within 30 days of the birth by completing the enrollment form to add the child to your coverage. If you are changing your type of coverage (for example from individual to family coverage) in order to cover the newborn child, you must complete the enrollment form to extend your coverage to include your child within 30 days of the birth. If you do not complete the form within 30 days of the birth, coverage of the child will not become effective until the next premium due date after we receive the application. If a child of yours who is covered under this Certificate gives birth, your newborn grandchild will not be covered (unless any of the criteria of Paragraph 2 above apply).
4. **Adopted Newborns.** If you have a type of coverage that will cover a newborn, or switch to a type of coverage that will cover a newborn, in accordance with Paragraph 3 above, we will cover a proposed adoptive newborn from the moment of birth if you (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the Hospital after birth and you file a petition within 30

days of the infant's birth pursuant to §115-C of the New York State Domestic Relations Law or a comparable provision when the child is adopted in another state. However, we will not provide coverage for the initial Hospital stay of an adopted newborn if one of the child's natural parents has coverage available to cover the newborn's initial Hospital stay. We will also not provide coverage for the newborn if a notice of revocation of the adoption has been filed or one of the natural parents revokes consent to the adoption. If we provide coverage of an adopted newborn and notice of the revocation of the adoption is filed or one of the natural parents revokes their consent, we will be entitled to recover any sums paid by us for care of the adopted newborn.

5. **Types Of Coverage Other Than Individual Coverage.** We offer different types of coverage in addition to individual coverage:

- A. Family Coverage — If family coverage applies, then you, the Subscriber, and your spouse and your children as described above are covered.
- B. Spousal Coverage — If spousal coverage applies, then only you, the Subscriber, and your spouse as described above are covered.
- C. Child Coverage — If child coverage applies, then you, the Subscriber, and your child or children as described above are covered.
- D. Two-Person Coverage — If two-person coverage applies, then you, the Subscriber, and your spouse or one child as described above are covered. You may only select two-person coverage if your family unit consists of two people.

The names of all persons covered under this Certificate must have been specified on the enrollment form for this Certificate or provided to us as described in Paragraph 8 below. No one else can be substituted for those persons. We have administrative rules to determine which types of coverage are available to members of your group. You are only entitled to the types of coverage for which we receive premium and that our records indicate is applicable. You may call us if you have any questions about which type of coverage applies to you.

6. **When Coverage Begins.** Coverage under this Certificate will begin as follows:

- A. If you, the Subscriber, 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 Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible, you must wait until the group's next open enrollment period, except as provided in Paragraph 7 below. When you enroll during the next open enrollment period, coverage then begins at 12:01 a.m. on the date to which the open enrollment period applies.
- C. If you, the Subscriber, marry while covered, and we receive notice of such marriage within 30 days thereafter, coverage for your spouse starts at 12:01 a.m. on the date of your marriage. If we do not receive notice of the marriage within the 30-day period, your spouse must wait until the next open enrollment period for coverage. When your spouse is enrolled during the next open enrollment period, coverage for your spouse will start at 12:01 a.m. on the date to which the open enrollment period applies.

7. **When You Reject Initial Enrollment Or Elect Not To Enroll During Open Enrollment, But Do Not Need To Wait Until The Group's Next Open Enrollment Period To Enroll For Coverage.** If you, the Subscriber, reject initial enrollment under this Certificate, or elect not to enroll during a subsequent open enrollment, you may enroll for coverage if the following conditions are met:

- A. You or your spouse 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 spouse lost eligibility for one or more of the following reasons:

- (1) Termination of employment;
 - (2) Termination of the other plan or contract;
 - (3) Death of the spouse;
 - (4) Legal separation, divorce or annulment;
 - (5) Reduction in the number of hours worked;
 - (6) The employer or other group ceased its contribution toward the premium for the other plan or contract;
 - (7) The coverage was under an HMO, and you no longer live, work or reside in the HMO service area;
 - (8) Cessation of dependent child status;
 - (9) Benefits are no longer offered to similarly situated individuals (e.g., part-time employees);
 - (10) The benefit maximum under the plan or contract has been reached; or
- C. You acquire a dependent due to birth, adoption, guardianship, placement for adoption or marriage, in which case you, the Subscriber, may enroll for individual coverage or for a type of coverage available to your group that will cover you and your eligible dependents.
- D. You apply for coverage under this Certificate within 30 days after: termination for one of the reasons set forth in Subparagraph B above; or acquisition of a dependent as set forth in Subparagraph C above.

If you enroll for coverage pursuant to Subparagraphs A and B above, your coverage will begin at 12:01 a.m. on the date of the loss of coverage. 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.

8. 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 (other than a newborn child added under Paragraph 3 or 4 above), you must complete and return to us a form for this purpose and any requested documentation. The addition of a spouse or child will be effective as of the date of marriage, adoption or other event making the child eligible for coverage under Paragraph 2, if you return to us a completed application and requested documents within 30 days of the wedding, adoption or other event, and the applicable premium is paid. If you do not return a completed form and documentation within 30 days, your spouse or child will be added to your coverage after the next open enrollment period, so long as the applicable premium is paid.
- B. **When Coverage of a Spouse or Child Terminates.** If you have other than individual coverage, you should notify us of any event that affects your coverage, such as: your divorce, the death of your spouse or Medicare eligibility; or a child marrying, leaving school, reaching the age at which coverage terminates or otherwise experiencing an event that would normally result in termination of dependent coverage. We will provide you with a form for that purpose. If such change results in you seeking a different type of coverage at a lower premium (such as a switch to individual coverage), the form and requested documentation must be returned within 30 days of the event in order for the change in premium to be effective on the date of the event. If you do not return a completed form and any requested documentation within 30 days of the event, the change in premium will be effective as of the next premium due date after they are received. Nothing in this Subparagraph B is designed to affect the provisions of Section Fourteen governing terminations of coverage. This Subparagraph B only involves the effective date of changes in premiums due to terminations of coverage under Section Fourteen.

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

SECTION THREE — MEDICAL NECESSITY

1. **Care Must Be Medically Necessary.** We will provide coverage under this Certificate for the covered benefits described in this Certificate 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 we have to provide coverage for it.

We will decide whether a Service was Medically Necessary. We will base our decision in part on a review of your medical records. We will also evaluate medical opinions we receive. 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, we will also consider:

- A. Reports in peer reviewed medical literature;
- B. Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- C. Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care or treatment;
- D. The opinion of health professionals in the generally recognized health specialty involved;
- E. The opinion of the attending Professional Providers, which have credence but do not overrule contrary opinions; and
- F. Any other relevant information brought to our attention.

Services will be deemed Medically Necessary only if:

- A. They are clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease;
 - B. They are required for the direct care and treatment or management of that condition;
 - C. If not provided, your condition would be adversely affected;
 - D. They are provided in accordance with generally-accepted standards of medical practice;
 - E. They are not primarily for the convenience of you, your family, the Professional Provider or another provider;
 - F. They are not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease; and
 - G. When you are an inpatient, your medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided to you in any other setting (e.g., outpatient, physician's office or at home).
2. **Service Must Be Approved Standard Treatment.** Except as otherwise required by law, no Service rendered to you will be considered Medically Necessary unless we determine that the Service is consistent with the diagnosis and treatment of your medical condition; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative.

Please see Section Sixteen, paragraph 29 for your right to an external appeal of our determination that a Service is not Medically Necessary.

SECTION FOUR — COST SHARING EXPENSES

1. **Copayments.** The Copayments you must pay for covered services rendered by Participating and Non-Participating Providers are set forth in the section where the particular service is described.
2. **Additional Payments For Services Of Non-Participating Providers.** When you receive covered services from a Non-Participating Provider, in addition to the Copayment described above, you must also pay the amount, if any, by which the provider's actual charge exceeds the Allowable Expense. This means that the total of our coverage and your Copayment may be less than the provider's actual charge.

SECTION FIVE — INPATIENT CARE

1. **In A Facility.** If you are a registered bed patient in a Facility, we 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.** We will not provide coverage for:
 - A. Additional charges for special duty nurses;
 - B. Private room, unless we determine that it is Medically Necessary for you to occupy a private room or the Facility has no semi-private rooms. If you occupy a private room in a Facility, and we determine that a private room is not Medically Necessary or that the Facility does have semi-private rooms, our 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 we will provide coverage for blood required for the treatment of hemophilia. However, we 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 which you take home from the Facility; or
 - F. Custodial care. (See Section Eleven, paragraph 8.)
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.** We will provide coverage when you are required to stay in a Hospital for acute medical or surgical care and are not admitted to the hospital for mental health care or for diagnosis and treatment of chemical dependence and/or abuse. We will provide coverage for any day on which it is Medically Necessary for you to receive inpatient care. (See Subparagraphs B, C, D, E and F below for limitations and exclusions on our coverage for mental health care, inpatient detoxification, Skilled Nursing Facility care, physical rehabilitation and inpatient chemical dependence and abuse rehabilitation.)
 - B. **Mental Health Care.** We will provide coverage for diagnosis and treatment of Mental Illnesses for up to 30 days of "active treatment" in a Calendar Year in a hospital as defined by subdivision ten of section 1.03 of the New York Mental Hygiene Law. The term "active treatment" means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meets standards prescribed pursuant to the regulations of the Commissioner of Mental Health.

We will also provide coverage for care in a licensed partial hospitalization program. A partial hospitalization program is an ambulatory treatment program that provides a medically supervised alternative to inpatient treatment. One day's care in a partial hospitalization program will be

considered inpatient care and will be counted as one-half of a day of care toward meeting the maximum number of days of care available to you in a Calendar Year for inpatient care of Mental Illnesses.

Services of Participating and Non-Participating Providers for mental health care will both be counted toward the day limit that applies to inpatient mental health care.

The coverage described above includes benefits for Biologically-Based Mental Illness and for Children with Serious Emotional Disturbances; however, benefits for Biologically-Based Mental Illness and Children with Serious Emotional Disturbances are not subject to the 30-day Calendar Year limit set forth above. We will provide coverage for any day on which it is Medically Necessary for you to receive inpatient care for these conditions.

- C. **Inpatient Detoxification.** We will not provide coverage for active treatment for detoxification needed because of chemical dependence.
 - D. **Skilled Nursing Facility.** We will not provide coverage for care in a Skilled Nursing Facility.
 - E. **Physical Rehabilitation.** We will provide coverage for comprehensive physical medicine and rehabilitation (chemical dependence and abuse programs are excluded) for up to 60 days per Calendar Year for a condition that in the judgment of your Professional Provider and the Medical Director can reasonably be expected to result in significant improvement within a relatively short period of time. Services of Participating and Non-Participating Providers for physical rehabilitation will both be counted toward the 60-day limit.
 - F. **Inpatient Chemical Dependence and Abuse Rehabilitation.** We will not provide coverage for the diagnosis and active treatment for rehabilitation of chemical dependence and abuse.
- 4. **Maternity Care.** We will provide coverage for inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, if covered under this Certificate, 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. We will also provide coverage for any additional days of such care that we determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum coverage period, we will provide coverage of the home care visit furnished by the type of home care agency described in Section Seven of this Certificate. 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. Our coverage of this home care visit shall not be subject to any Copayment amounts.
 - 5. **Mastectomy Care.** Our 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. We will also provide coverage for prostheses and treatment of physical complications of the mastectomy, including lymphedemas.
 - 6. **Infertility Treatment Services.** We will provide coverage for Medically Necessary inpatient Hospital care in connection with infertility treatment services described in Section Six, paragraph 14.
 - 7. **Internal Prosthetic Devices.** Our coverage for inpatient Hospital care includes coverage for internal prostheses that are surgically implanted and Medically Necessary for anatomical repair or reconstructive purposes. Internal prosthetic devices are designed to replace all or part of a permanently inoperative, absent or malfunctioning body organ. Examples of internal prosthetic devices include: cardiac pacemakers, implanted cataract lenses and surgically implanted hardware necessary for joint repair or reconstruction.

8. **Observation Stay.** We will provide coverage for observation services for up to 48 hours. Observation services are: furnished in the outpatient department of a Facility; and are in lieu of an inpatient admission. The services include: use of a bed; and periodic monitoring by nursing or other licensed staff that is reasonable and necessary to evaluate the patient's condition or determine the need for an inpatient admission.
9. **End Of Life Care.** We will provide coverage for acute care services at a Facility licensed pursuant to Article 28 of the Public Health Law that specializes in the treatment of terminally ill patients when you are diagnosed with advanced cancer and have fewer than 60 days to live. We will cover your care when your attending physician, in consultation with the medical director of the Facility, determines that your care would appropriately be provided by the Facility. If we disagree with your admission to the Facility, we have the right to initiate an expedited appeal to the external appeal agent described in Section Sixteen, paragraph 29 of this Certificate. However, until the external appeal agent renders a decision in our favor, we will provide coverage and reimburse the Facility for your care, subject to any applicable limitations in this Certificate.
10. **Benefits For Inpatient Care.**
 - Participating Providers.** Services of Participating Providers are covered at 100% of the Allowable Expense.
 - Non-Participating Providers.** Services of Non-Participating Providers are covered at 100% of the Allowable Expense.

SECTION SIX — OUTPATIENT CARE

We will provide coverage for the same services we 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.** We will only provide coverage if we determine that it was Medically Necessary to use the Facility to perform the surgery.
2. **Pre-Admission Testing.** We will provide coverage for tests ordered by a physician which are given to you as a preliminary to your admission to the Facility as a registered bed patient for surgery if all of the following conditions are met:
 - A. They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;
 - B. A reservation has been made for the Facility bed and/or the operating room before the tests are given;
 - C. You are physically present at the Facility when these tests are given; and
 - D. Surgery actually takes place within seven days after the tests are given.
3. **Diagnostic And Routine Imaging.** We will provide coverage for diagnostic and routine imaging procedures, including x-rays, ultrasound, CAT and PET scans and magnetic resonance imaging ("MRI") procedures.
4. **Laboratory And Pathology Services.** We will provide coverage for diagnostic and routine laboratory and pathology services.
5. **Radiation Therapy And Chemotherapy.** We will provide coverage for radiation therapy and chemotherapy.
6. **Hemodialysis.** We will provide coverage for hemodialysis treatments of an acute or chronic kidney ailment.

7. **Mammography Screenings.** We will provide coverage for mammography screenings for occult breast cancer according to our preventive care guidelines. At a minimum, our coverage will be as follows:
 - A. **Women at Risk.** We will provide coverage for mammograms for women of any age who have a prior history of breast cancer or who have a first degree relative (such as a child, mother or sister) or a paternal or maternal grandmother who has a prior history of breast cancer, if the mammogram is recommended by a physician.
 - B. **Women 35 through 39 Years of Age.** We will provide coverage for one baseline mammogram for women 35 through 39 years of age.
 - C. **Women 40 Years of Age and Older.** We will provide coverage for one mammogram in each Calendar Year for women 40 years of age and older.

Mammography screening includes, but is not limited to, an x-ray examination of the breast using dedicated equipment, including x-ray tube; filter; compression device; screens; films and cassettes, with an average glandular radiation dose of less than 0.5 rem per view per breast.

8. **Cervical Cytology Screenings (Pap Smears).** We will provide coverage for screening for cervical cancer and its precursor states for women 18 years of age or older, or for younger women who are sexually active, according to our preventive care guidelines. At a minimum, we will provide coverage for one screening each Calendar Year for women age 18 and older. 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.
9. **Mental Health Care.** We will provide benefits for up to 20 visits in a Calendar Year for diagnosis and treatment of Mental Illnesses in a facility that: has an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; or is operated by the Office of Mental Health.

Services provided in a practitioner's office under your Basic Medical Certificate and in a facility pursuant to this section are subject to the visit limit above.

Services of Participating and Non-Participating Providers for mental health care will both be counted toward this 20-visit maximum.

The coverage described above includes benefits for Biologically-Based Mental Illness and for Children with Serious Emotional Disturbances; however, benefits for Biologically-Based Mental Illness and Children with Serious Emotional Disturbances are not subject to the 20-visit limit set forth above. We will provide coverage for all Medically Necessary visits for these conditions.

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

We will provide coverage for up to an aggregate of 60 outpatient visits per Member each Calendar Year. Up to 20 of the 60 visits may be used for family therapy. Family therapy consists of visits that include members of your family in order for your family to understand the illness of another family member and play a meaningful role in the family member's recovery. Our coverage of a family visit will be the same regardless of the number of family members who attend the family visit. The family therapy visits may only be used by people who are covered under this Certificate.

Services of Participating and Non-Participating Providers will both be counted toward this 60-visit maximum.

11. **Covered Therapies.** We will not provide coverage for related rehabilitative physical therapy and physical, occupational and speech therapy.

12. **Pulmonary Rehabilitation.** We 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. We will provide coverage for one program per lifetime.
13. **Cardiac Rehabilitation.** We 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. We will provide coverage for one program per lifetime.
14. **Infertility Treatment Services.** We will provide coverage for Medically Necessary services for the diagnosis and treatment of infertility subject to the following conditions:
 - A. **Infertility Defined.** For the purposes of this paragraph, infertility has the meaning set forth in the regulations of the New York State Insurance Department. In general, infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse.
 - B. **Coverage Provided for Individuals 21 to 44 Years of Age.** The benefits provided by this paragraph are available only to Members covered under this Certificate who are between the ages of 21 and 44 as of the date the services are rendered.
 - C. **Coverage Only Provided for Appropriate Candidates.** Coverage under this paragraph will only be provided to "Appropriate Candidates" within the age group described in Subparagraph B. An Appropriate Candidate is an individual determined to be an Appropriate Candidate by the treating physician, in accordance with the standards and guidelines established and adopted by the New York State Insurance Department by regulation.
 - D. **Covered Services.** Subject to the other provisions of this paragraph and your Certificate, we will provide benefits under this paragraph for:
 - (1) Medical and surgical procedures, such as artificial insemination, intrauterine insemination, and dilation and curettage ("D & C"), that would correct malformation, disease or dysfunction resulting in infertility; and
 - (2) Services in relation to diagnostic tests and procedures necessary:
 - (a) To determine infertility; or
 - (b) In connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered by this paragraph are:
 - (i) Hysterosalpingogram;
 - (ii) Hysteroscopy;
 - (iii) Endometrial biopsy;
 - (iv) Laparoscopy;
 - (v) Sono-hysteroqram;
 - (vi) Post-coital tests;
 - (vii) Testis biopsy;
 - (viii) Semen analysis;
 - (ix) Blood tests;
 - (x) Ultrasound; and
 - (xi) Other Medically Necessary diagnostic tests and procedures, unless excluded by law.

- E. **Plan of Care Required.** All services covered under this paragraph must be prescribed by a physician as part of a "plan of care." The plan of care must be in writing, and must be available for review by us. Services or procedures that are inconsistent with or not included in the plan of care will not be covered.
 - F. **Services Must be Received from Eligible Providers.** Services covered by this paragraph must be received from "Eligible Providers" as determined by us in accordance with applicable regulations of the New York State Insurance Department. In general, an Eligible Provider is defined as a health care provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine.
 - G. **Excluded Services.** We will not pay benefits for the following reproductive procedures or services:
 - (1) In-Vitro Fertilization;
 - (2) Gamete Intra-Fallopian Transfer (GIFT);
 - (3) Zygote Intra-Fallopian Transfer (ZIFT);
 - (4) Reversal of elective sterilizations, including vasectomies and tubal ligations;
 - (5) Sex change procedures;
 - (6) Cloning;
 - (7) Sperm banking and donor fees associated with artificial insemination or other procedures;
 - (8) Other procedures or categories of procedures excluded by statute.
 - H. **Experimental Procedures Not Covered.** This paragraph does not cover services or procedures that we determine to be experimental, according to standards and guidelines that are no less favorable than those established and adopted by the American Society for Reproductive Medicine. You may appeal our determination that a service or procedure is experimental to an external appeal agent as described in Section Sixteen, paragraph 29.
15. **Screenings For Prostate Cancer.** We will provide coverage for diagnostic screenings for prostate cancer, including standard diagnostic testing and standard diagnostic exams, according to our preventive care guidelines. At a minimum, we will provide coverage for prostate screenings as follows:
- A. **Men with a Prior History of Prostate Cancer.** We will provide coverage for standard diagnostic testing for men of any age who have had a prior history of prostate cancer.
 - B. **Men at Risk.** We will provide coverage for one standard diagnostic exam in each Calendar Year for men over the age of 40 who have a family history of prostate cancer or who have other risk factors for prostate cancer.
 - C. **Men 50 Years of Age or Older.** We will provide coverage for one standard diagnostic exam in each Calendar Year for men 50 years of age and older.

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

16. **Benefits For Outpatient Care.**

Participating Providers. Services of Participating Providers are covered at 100% of the Allowable Expense.

Non-Participating Providers. Services of Non-Participating Providers are covered at 100% of the Allowable Expense.

17. Individual Case Management.

- A. **Alternative Benefits.** If you agree to participate and abide by our policies, in addition to benefits specified in this Certificate, we may provide, outside the terms of this Certificate, benefits for services, for up to a 60-day period, furnished by any Participating Provider pursuant to the alternative treatment plan of ours for a Member whose condition would otherwise require hospitalization.

We may provide such alternative benefits if and only for so long as we determine, 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 Certificate in the absence of alternative benefits.

If we elect to provide alternative benefits for a Member in one instance, it shall not obligate us 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 our right to administer this Certificate thereafter in strict accordance with its expressed terms.

At the expiration of such 60-day period, you may apply in writing for a continuation of the alternative benefits and services being provided outside the terms of this Certificate. Upon such application for renewal, we will review the patient's condition and may agree to a renewal of such alternative benefits and services. Renewals must be in writing and our determination will be final.

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

- B. **Appeals of Individual Case Management.** If we deny 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 our Member Services Department at the phone number located on your identification card.

SECTION SEVEN — HOME CARE

1. **Type Of Home Care Provider.** We will provide coverage for home care visits given by a certified home health agency or licensed home care services agency if your Professional Provider and our 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.** We will provide coverage for home care only if all the following conditions are met:
- A. A treatment plan is established and approved in writing by your Professional Provider;
 - B. You apply to the home care provider through your Professional Provider with supporting evidence of your need and eligibility for the care; and

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

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

- 3. **Home Care Services Covered.** Home care will consist of one or more of the following:
 - A. Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse;
 - B. Part-time or intermittent home health aide services that consist primarily of direct care rendered to you;
 - C. Physical, occupational or speech therapy provided by the home health agency or home care services agency; and
 - D. Medical supplies, drugs and medications prescribed by your physician, laboratory services, durable medical equipment and infusion therapy, when provided by or on behalf of the home health agency or home care services agency, but only to the extent such items would have been covered under this Certificate 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 Treatment Plan.** If you fail or are unable to comply with the home care treatment plan, we will terminate benefits for that plan of care.
- 5. **Number Of Days.** We will provide coverage for up to 60 days of home care in a Calendar Year, beginning with the first day on which care is provided.

Services of Participating and Non-Participating Providers will both be counted toward the 60-day limit.

- 6. **Benefits For Home Care.**

Participating Providers. Services of Participating Providers are covered at 100% of the Allowable Expense.

Non-Participating Providers. Services of Non-Participating Providers are covered at 100% of the Allowable Expense.

SECTION EIGHT — HOSPICE CARE

- 1. **Eligibility For Benefits.** In order to receive these benefits, which are non-aggressive services provided to maintain the comfort, quality and dignity of life to the terminally ill patient, you must meet the following conditions:
 - A. The attending physician estimates your life expectancy to be six months or less.
 - B. Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.
- 2. **Hospice Organizations.** In New York State we will provide coverage only for hospice care provided by a hospice organization that has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the hospice organization must have an operating certificate issued under criteria similar to those used in New York by a state agency in the state where the hospice care is provided, or it must be approved by Medicare.
- 3. **Hospice Care Benefits.** We will provide coverage for the following services when provided by a hospice:
 - A. Bed patient care provided by the hospice organization either in a designated hospice unit or in a regular hospital bed;

- B. Day care services provided by the hospice organization;
- C. Home care and outpatient services which are provided and billed through the hospice. The services may include at least the following:
 - (1) Intermittent nursing care by an R.N., L.P.N. or home health aide;
 - (2) Physical therapy;
 - (3) Speech therapy;
 - (4) Occupational therapy;
 - (5) Respiratory therapy;
 - (6) Social services;
 - (7) Nutritional services;
 - (8) Laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms;
 - (9) Medical supplies;
 - (10) Drugs and medications that require a prescription by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary. We will not provide coverage when the drug or medication is of an experimental nature (see Section Sixteen, paragraph 29 for your right to an external appeal of our determination that a drug is experimental);
 - (11) Durable medical equipment; and
 - (12) Bereavement services provided to your family during illness, and until one year after death.
- D. Medical care provided by a physician.

4. **Number Of Visits.** We will provide coverage for unlimited days of hospice care, beginning with the first day on which care is provided. Each day you receive care from or through the hospice counts as a day of hospice care. We will also provide coverage for up to five visits for bereavement counseling services to your family, either before or after your death.

5. **Benefits For Hospice Care.**

Participating Providers. Services of Participating Providers are covered at 100% of the Allowable Expense.

Non-Participating Providers. Services of Non-Participating Providers are covered at 100% of the Allowable Expense.

SECTION NINE — EMERGENCY CARE

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

1. **Eligibility For Benefits.** We will provide coverage for care at the emergency room or freestanding urgent care center of a Participating or Non-Participating Provider, if your illness or condition is considered an Emergency Condition.

When you make visits to the emergency room for a condition that is not an Emergency Condition, you will be liable for the entire charge for the visit including all associated charges such as, but not limited to, x-ray, laboratory services and medication expenses.

2. **Pre-hospital Emergency Services And Transportation.** We will provide coverage for services to evaluate and treat an Emergency Condition when such services are provided by an ambulance service certified under the Public Health Law. We will also 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.
3. **Ambulance Service.** In addition to the services described in Paragraph 2 above, we will also provide coverage for the following Medically Necessary services provided by a certified ambulance service:
 - A. Ground or air ambulance service for an urgent condition. When you have an urgent condition, the need for care is less than the need for care of an Emergency Condition, but the condition requires immediate attention. An urgent condition is one that may become an Emergency Condition in the absence of treatment.
 - B. Air ambulance service for an Emergency Condition.
 - C. Transportation between Facilities.
4. **Benefits.**

Participating Providers. Services of Participating Providers are covered at 100% of the Allowable Expense.

Non-Participating Providers. Services of Non-Participating Providers are covered at 100% of the Allowable Expense.

SECTION TEN — HUMAN ORGAN AND BONE MARROW TRANSPLANTS

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

1. **Prior Approval Required.** All organ transplants must be pre-approved by us. You or your Professional Provider must call us 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 us within 24 hours after your admission or as soon thereafter as reasonably possible. If you fail to seek our prior approval for an organ transplant, we will provide coverage for an amount \$500 less than we would otherwise cover for the care, or we will provide coverage for only 50% of the amount we would otherwise have covered for the care, whichever results in a greater benefit to you. You must pay the remaining charges. We will provide coverage for the amount specified above only if we determine the care was Medically Necessary even though you did not seek our prior approval. If we determine, 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 transplant centers certified or otherwise approved by the appropriate regulatory authority for the specific type of transplant procedure being performed. The types of organ transplants that must be performed in certified transplant centers are: bone marrow; liver; heart; lung; heart-lung; kidney; and kidney-pancreas. You may contact us if you wish to obtain a list of certified transplant centers.
3. **No Coverage Of Experimental Or Investigational Organ Transplants.** We will not provide coverage for any benefits for an organ transplant we determine to be experimental or investigational. We maintain and revise from time to time a list of organ transplant procedures which we determine not to be experimental or investigational and therefore are covered under this Certificate. You may contact us if you

have a question concerning whether a particular transplant procedure is covered. See Section Sixteen, paragraph 29 for your right to an external appeal of our determination that an organ transplant is experimental or investigational.

4. **Recipient Benefits.** We will provide coverage for a person covered under this Certificate for all of the benefits provided to the recipient of the organ transplant that are otherwise covered under this Certificate when they result from or are directly related to a covered organ or bone marrow transplant.
5. **Coverage For Donor Searches Or Screenings.** We will not provide coverage for costs relating to searches or screenings for donors of organs.
6. **Costs Of Organ Donor.** We will provide coverage for the medical services directly related to the donation of an organ for transplantation to a person covered under this Certificate. We will not provide coverage if you are donating an organ for transplantation to a person not covered under this Certificate.

SECTION ELEVEN — EXCLUSIONS

In addition to the exclusions and limitations described in other sections of this Certificate, we will not provide coverage for the following:

1. **Acupuncture.** We will not provide coverage for any service or care related to acupuncture treatment and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery.
2. **Blood Products.** We 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 we will provide coverage for blood required for the treatment of hemophilia when billed by a Facility. When not free in the local area, we 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.
3. **Certification Examinations.** We 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.
4. **Contraceptive Drugs And Devices.** We will not provide coverage for any service or care related to contraceptive drugs or devices, including, but not limited to, family planning services, implantable drugs, intra-uterine devices and diaphragms.
5. **Cosmetic Services.** We 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 we often determine to be not Medically Necessary include the following: breast enlargement, rhinoplasty and hair transplants. We 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. We will also provide coverage for reconstructive surgery because of congenital disease or anomaly of a child covered under this Certificate that has resulted in a functional defect. We will also provide coverage for services in connection with reconstructive surgery following a mastectomy.
6. **Court-Ordered Services.** We 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 Certificate in the absence of a court order;
 - B. Our 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 Certificate.

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

7. **Criminal Behavior.** We 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.
8. **Custodial Care.** We will not provide coverage for any service or care that is custodial in nature, or any therapy that we determine is not expected to improve your condition. Care is considered custodial when it is primarily for the purpose of meeting personal needs and includes activities of daily living such as help in transferring, bathing, dressing, eating, toileting, and such other related activities.
9. **Dental Care.** We will not provide coverage for any service or care (including anesthesia and inpatient stays) for treatment of the teeth, gums, or structures supporting the teeth; or any form of dental surgery; regardless of the reasons(s) that the service or care is necessary. For example, we will not provide coverage for x-rays, fillings, extractions, braces, prosthetics, correction of impactions, treatments for gum disease, therapy or other treatments related to dental TMJ disorder or dental oral surgery. We 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. In addition, we will provide the benefits set forth in this Certificate for service and care for treatment of sound natural teeth provided within 12 months of an accidental injury. We do not consider an injury to a tooth caused by chewing or biting to be an accidental injury. We will also provide coverage for the services set forth in this Certificate that we determine are Medically Necessary for treatment of a congenital anomaly or disease that was evident and observable at birth and caused by a medical condition that was present at birth. We will also provide coverage for the services set forth in this Certificate that we determine are Medically Necessary for treatment of cleft palate and ectodermal dysplasia. We will cover institutional provider services for dental care when we determine there is an underlying medical condition requiring these services.
10. **Developmental Delay.** We will not provide coverage for educational services related to evaluation, testing and treatment of behavioral disorders, learning disabilities, minimal brain dysfunction, development and learning disorders, or developmental delays. We will also not provide benefits for any covered service or care set forth in this Certificate when rendered in connection with such conditions, unless Medically Necessary.
11. **Durable Medical Equipment; Prosthetic Devices; Medical Supplies; Disposable Supplies; Hair Prosthetics; Household Fixtures.** We will not provide coverage for any service or care related to:
 - A. The rental, purchase, repair, or maintenance of durable medical equipment (for example, respirators, canes, crutches, walkers, wheelchairs, trusses, apnea monitors, oxygen-related equipment, special hospital-type beds, or home dialysis units);
 - B. Prosthetic devices (except as set forth in Section Five, paragraphs 5 and 7), (for example, artificial arms, legs and eyes, and ostomy bags and supplies required for their use);
 - C. Medical supplies (for example, bandages, surgical gloves and compression stockings);
 - D. Disposable supplies (for example, diapers, chux, sponges, syringes, incontinence pads, reagent strips and bandages purchased for general use);
 - E. Wigs, hair prosthetics, or hair implants;
 - F. Orthotics, including, but not limited to, custom-made shoes and arch supports; and
 - G. The purchase or rental of household fixtures, including, but not limited to, elevators, escalators, ramps, seat lift chairs, stair glides, saunas, whirlpool baths, swimming pools, home tracking systems, exercise cycles, air or water purifiers, hypo-allergenic pillows, mattresses or waterbeds, massage equipment, central or unit air conditioners, humidifiers, dehumidifiers, emergency alert equipment, handrails, heat appliances, improvements made to a house or place of business, and adjustments made to vehicles.
12. **Reversal Of Elective Sterilization.** We will not provide coverage for any service or care related to the reversal of elective sterilization.

13. **Experimental And Investigational Services.** Unless otherwise required by law, we 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 we determine that the Service is experimental or investigational. See Section Sixteen, paragraph 29 for your right to an external appeal of our determination that a Service is experimental or investigational.

"Experimental or investigational" means that we determine 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, we may, in our 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 Certificate 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.

14. **Free Care.** We 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 Certificate. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your spouse, brother, sister, mother, father, son or daughter; or the spouse of any of them; we will presume that the service or care would have been furnished without charge. You must prove to us that a service or care would not have been furnished without charge.
15. **Government Hospitals.** Except as otherwise required by law, we will not provide coverage for any service or care you receive in a Facility or institution which is owned, operated or maintained by: the Veterans Administration (VA); a federal, state, or local government, unless the Facility is a Participating Provider. However, we will provide coverage for services or care in such a Facility to treat an Emergency Condition. In this case, we will continue to provide coverage only for as long as we determine that emergency care is necessary and it is not possible for you to be transferred to another Facility.
16. **Government Programs.** Except as provided below when you are covered under Medicare, we will not provide coverage for any service or care for which benefits are payable under any federal, state, or local government program, except when required by state or federal law. When you are covered under Medicare, and Medicare is primary according to federal law, Medicare benefits and the benefits under this Certificate will be coordinated as set forth in Section Thirteen.

According to federal law, Medicare is not primary 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 Subscriber is in "current employment status" (working actively and not retired) with the group contract holder; and
 - (2) The Subscriber's employer maintains or participates in an employer group health plan that is required by law to have this Certificate 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 Subscriber is in "current employment status" (working actively and not retired) with the group contract holder; and
 - (2) The Subscriber's employer maintains or participates in a large group health plan, as defined by law, that is required by law to have this Certificate 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. During the waiting period, benefits under this Certificate are primary. We will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before we provide benefits under this Certificate.
17. **Hypnosis/Biofeedback.** We will not provide coverage for hypnosis or biofeedback.
 18. **Inpatient Rehabilitation For Chemical Dependence Or Abuse.** We will not provide coverage for inpatient rehabilitation for chemical dependence or abuse.
 19. **Military Service-Connected Conditions.** We will not provide coverage for any service or care related to any military service-connected disability or condition, if the Veterans Administration (VA) has the responsibility to provide the service or care.
 20. **No-Fault Automobile Insurance.** We 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. We will provide benefits for services covered under this Certificate 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, we will provide coverage for the services covered under this Certificate, up to the amount of the deductible. We will not provide benefits even if you bring a lawsuit against the person who caused your injury and even if you receive money from that lawsuit and you have repaid the medical expenses you received payment for under the mandatory automobile no-fault coverage.

21. **Non-Covered Service.** We will not provide coverage for any service or care that is not specifically described in this Certificate as a covered service; or that is related to service or care not covered under this Certificate; even when a Participating Provider considers the service or care to be Medically Necessary and appropriate. For example, this Certificate does not cover services provided and billed by a Professional Provider.
22. **Nutritional Therapy.** We will not provide coverage for any service or care related to nutritional therapy, unless we determine that it is Medically Necessary or that it qualifies as diabetes self-management education. We will not provide coverage for commercial weight loss programs or other programs with dietary supplements.
23. **Personal Comfort Services.** We will not provide coverage for the following service or care that is for personal comfort: radio, telephone, television, or beauty and barber services.
24. **Prescription Drugs.** We will not provide coverage for service or care related to prescription drugs, over-the-counter (nonprescription) drugs, or injections, except for: prescription drugs, and/or injections that are administered to you in the course of a covered outpatient or inpatient treatment in a Facility, or through home health care benefits.
25. **Private Duty Nursing Service.** We 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.
26. **Prohibited Referral.** We will not provide coverage for any pharmacy, clinical laboratory, radiation therapy, physical therapy, x-ray, or imaging services that were provided pursuant to a referral prohibited by the New York Public Health Law.
27. **Reproductive Procedures.** We will not provide coverage for the following reproductive procedures or services: in vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cloning, sperm banking and donor fees associated with artificial insemination or other procedures, or other procedures or categories of procedures excluded by statute.
28. **Routine Care Of The Feet.** We will not provide coverage for services or for arch supports, foot inserts, other foot devices or orthopedic shoes 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. We will, however, provide coverage for arch supports, foot inserts, other foot devices and orthopedic shoes under your benefits for orthotic devices.
29. **Self-Help Diagnosis, Training And Treatment.** We will not provide coverage for any service or care related to self-help or self-care diagnosis, training and treatment for recreational, educational, vocational or employment purposes.
30. **Services Covered Under Hospice Care.** If you have been formally admitted to a hospice program and we are providing coverage for your hospice care under this Certificate, we will not provide additional coverage under this Certificate for any services related to your terminal illness that have been or should be included in our payment to the hospice program for the care you receive. However, should you require services covered under this Certificate for a condition not covered under the hospice program, coverage will be available under this Certificate for those covered services.
31. **Services Starting Before Coverage Begins.** If you are receiving care on the Effective Date of your coverage under this Certificate, we will not provide benefits for any service or care you receive:
 - A. Prior to the Effective Date of your coverage under this Certificate; or

- B. On or after the Effective Date of your coverage under this Certificate, if that service or care is covered under any other health benefits contract, program, or plan.
32. **Smoking Cessation Programs.** We will not provide coverage for smoking cessation programs.
33. **Special Charges.** We will not provide coverage for charges billed to you for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, or completion of claims forms. This exclusion applies to any late charges or extra day charges that you incur upon discharge from a Facility, because you did not leave the Facility before the Facility's discharge time.
34. **Social Counseling And Therapy.** We will not provide coverage for any service or care related to family, marital, religious, sex, or other social counseling or therapy, except as otherwise provided under this Certificate.
35. **Transsexual Surgery And Related Services.** We will not provide coverage for surgery, or for any service or care set forth in this Certificate that is related or leads up to such surgery, that is designed to alter the physical characteristics of your biologically determined gender to those of another gender, unless Medically Necessary.
36. **Unlicensed Provider.** We 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.
37. **Vision; Hearing; Vision And Hearing Examinations, Therapies And Supplies.** We will not provide coverage for any service or care related to:
- A. Routine eye or hearing examinations for the purpose of prescribing, fitting, servicing, or changing eyeglasses, contact lenses or hearing aids; except for the initial prescription for contact lenses or lenses and frames after cataract surgery;
 - B. Eyeglasses, lenses, frames, contact lenses or hearing aids except for the initial prescription for contact lenses or lenses and frames after cataract surgery; and
 - C. Vision or hearing therapy, vision training, or orthoptics.
38. **Weight Loss Services.** We will not provide coverage for any service or care in connection with weight loss programs. We will also not provide benefits for any covered service or care set forth in this Certificate when rendered in connection with weight reduction or dietary control, including, but not limited to, laboratory services, and gastric stapling, gastric by-pass, gastric bubble or other surgery for treatment of obesity, unless Medically Necessary.
39. **Workers' Compensation.** We will not provide coverage for any service or care for which benefits are provided under a workers' compensation or similar law.

SECTION TWELVE — WAITING PERIODS

1. **Pre-existing Conditions.** We will not provide coverage for any services related to a Pre-existing Condition until you have been continuously covered under this Certificate for at least 12 consecutive months, subject to crediting for prior coverage under Paragraph 2 below. This provision will not apply if your group has more than 300 members.

A Pre-existing Condition is any physical or mental condition; disease; or ailment for which medical advice, diagnosis, care or treatment was actually recommended or received by a licensed health care provider within the six-month period preceding your Enrollment Date. The Enrollment Date is the first of the following:

- A. Your Effective Date under this Certificate; or
- B. The first day of the waiting period that your group requires you to meet before you are eligible for coverage.

2. **Credit Toward Waiting Periods.** The time you were covered under any other health insurance or HMO contract or policy or employer-provided health benefit arrangement providing creditable coverage as defined by the Health Insurance Portability and Accountability Act before you became covered under this Certificate will be counted toward the waiting period if there was not a break in coverage greater than sixty-three (63) days between the termination of the previous coverage and your Enrollment Date under this Certificate. In the case of previous coverage any HMO affiliation period before coverage becomes effective shall be considered as time covered for purposes of providing credit for previous coverage.

Creditable coverage includes: coverage provided through health insurance; self-insured group health benefit plans; Medicaid; Medicare; government-sponsored health benefit programs, such as CHAMPUS, Peace Corps, or Indian Health Service; Federal Employees Health Benefits Program; a State health benefits risk pool; or coverage under a public health plan.

You have the right to obtain a certificate from the employer, insurer, HMO or governmental health benefit plan that provided your prior creditable coverage. The certificate will enable you to demonstrate the prior creditable coverage that will be counted toward fulfillment of the Pre-existing Condition waiting period under this Certificate. Contact us if you need help obtaining a certificate for your prior creditable coverage.

3. **Exceptions.** Pre-existing Condition waiting periods will not be imposed with respect to: (a) pregnancy; (b) any condition afflicting a newborn who is covered under creditable coverage on the 30th day following birth, provided that there has not been a continuous lapse of more than 63 days between the end of the creditable coverage and the child's enrollment date for coverage under this Certificate; (c) any condition afflicting an adopted child under age 18 who is covered under creditable coverage on the 30th day following adoption or placement for adoption, provided that there has not been a continuous lapse of more than 63 days between the end of the creditable coverage and the child's enrollment date for coverage under this Certificate; or (d) genetic information, including gene products; inherited characteristics that may derive from the individual or family member, including information regarding carrier status and information derived from lab tests that identify mutations in specific genes or chromosomes; physical medical examinations; family histories; and direct analysis of genes or chromosomes. However, if, within the six-month period prior to your Enrollment Date, you have been diagnosed with and have received medical advice or treatment for the condition indicated by the genetic information, the Pre-existing Condition waiting period will apply.

SECTION THIRTEEN — COORDINATION OF BENEFITS

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

1. **When You Have Other Health Benefits.** It is not unusual to find yourself covered by two health insurance contracts, plans 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, we will coordinate benefit payments with any payment made under the other plan. One company will pay its full benefit as the primary plan. The other company will pay secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance plan:
 - A. Any group or blanket insurance contract, plan or policy, including HMO and other prepaid group coverage, except that blanket school accident coverage or such coverage offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;
 - B. Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;
 - C. Any Blue Cross, Blue Shield, or other service type group plan;
 - D. Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and

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

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

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

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

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

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

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

3. **Payment Of The Benefit When This Plan Is Secondary.** When this plan is secondary, the benefits of this plan will be reduced so that the total benefits payable under the other plan and this plan do not exceed your expenses for an item of service. However, we will not pay more than we would have paid if we were primary.

We count 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. We will request information from that plan so we can process your claims. If the primary plan does not respond within 30 days, we will assume its benefits are the same as ours. If the primary plan sends the information after 30 days, we will adjust our payment, if necessary.

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

4. **Right To Receive And Release Necessary Information.** We have the right to release or obtain information that we believe necessary to carry out the purpose of this section. We 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. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information that we request. If you do not furnish the information to us, we have the right to deny payments.

5. **Payments To Others.** We may repay to any other person, insurance company or organization the amount which it paid for your covered services and which we decide we should have paid. These payments are the same as benefits paid.
6. **Our Right To Recover Overpayment.** In some cases we may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other plan. You must sign any document that we deem necessary to help us recover any overpayment.

SECTION FOURTEEN — TERMINATION OF YOUR COVERAGE

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

1. **Termination Of The Group Contract.** This Certificate is provided under the terms of the Group Contract between us and the group contract holder. The Group Contract is effective for one year and will automatically be renewed each year unless it is terminated as set forth below.
 - A. The group contract holder terminates the Group Contract pursuant to its terms. In this case, your coverage will terminate on the date the group contract holder terminates;
 - B. We do not receive premium payment from the group contract holder as of the date the premium was due. In this case, your coverage will end on the date to which the premium has been paid;
 - C. The group contract holder has committed fraud or made an intentional misrepresentation of material fact under the terms of the Group Contract. In this case, your coverage will terminate 30 days from the date we provide notice to you;
 - D. The group contract holder no longer qualifies as a group. We have certain administrative rules that describe our requirements for group contract holders. Our rules are consistent with New York State law and regulations governing health insurance. If you have a question about the rules that apply to your group contract holder, you may contact us and we will explain them to you.

When your group contract holder no longer meets our requirements, we will notify you. Your coverage will terminate 30 days from the date we provide notice to you;
 - E. The group contract holder fails to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under section 4235 of the Insurance Law. In this case, your coverage will terminate 30 days from the date we provide notice to you;
 - F. The group contract holder no longer has any enrollee living, residing or working in New York State. In this case, your coverage will terminate 30 days from the date we provide notice to you;
 - G. Any reason approved by the New York State Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act. In this case, your coverage will terminate 30 days from the date we provide notice to you;
 - H. If we terminate the entire class of contracts to which this Certificate belongs. In this case, your coverage will terminate 90 days from the date we provide notice to you; or
 - I. If we withdraw from the applicable market through which you obtained coverage under this Certificate, and we cease offering any products in that market. In this case, your coverage will terminate six months from the date we provide notice to you.

2. **Termination Of Your Coverage Under This Certificate.** In the following instances, the Group Contract will continue in force, but your coverage under this Certificate will be terminated:
- A. You choose to terminate your coverage. You must give the group contract holder 30 days' written notice. Your coverage will terminate on the date to which your premium is paid;
 - B. You are no longer a member of the group. Your coverage will terminate on the date to which your premium is paid if you are no longer a member of the group;
 - C. You committed fraud in applying for coverage or in filing a claim under this Certificate. Your coverage will terminate 30 days from the date we provide notice to you;
 - D. Any reason approved by the Superintendent of Insurance. In this case, your coverage will terminate 30 days from the date we provide notice to you. A copy of the reason for the termination of your coverage will be provided to you upon request;
 - E. On your death or the death of the Subscriber. Your coverage under this Certificate will automatically terminate on the date after your death or the death of the Subscriber;
 - F. Termination of the Subscriber's marriage. If the Subscriber becomes divorced, or the Subscriber's marriage is annulled, coverage of the Subscriber's spouse under this Certificate will automatically terminate on the date of the divorce or annulment; or
 - G. Termination of coverage of a child. Coverage of a Subscriber's child under this Certificate will terminate on the date the child no longer qualifies as a dependent under Section Two of this Certificate or, if later, the next premium due date after we receive notice of termination.
3. **Continued Benefits After Termination For Total Disability.** When your coverage under this Certificate ends, benefits stop. However, if we determine you are totally disabled on the date the Group Contract terminates, or on the date your coverage under this Certificate terminates, and you have received services or care for the illness, condition, or injury that caused your total disability while you were covered under this Certificate, continued benefits may be available to you as follows:
- A. **When you may continue benefits.** When you are totally disabled, you may continue benefits for covered services to treat the total disability when your coverage under this Certificate ends because:
 - (1) You are no longer actively employed;
 - (2) You are no longer eligible for coverage under this Certificate; or
 - (3) The Group Contract terminates;we will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within 31 days from the date your coverage ends. The Hospital stay and/or surgery must be for treatment of the injury, sickness, or pregnancy causing the total disability.
 - B. **When continued benefits end.** The continued benefits will terminate when:
 - (1) You have used all the benefits available;
 - (2) We determine that you are no longer totally disabled; or
 - (3) You reach the lifetime maximum amount payable by us.We will never pay more than we would have paid, had you remained covered under this Certificate.
4. **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. If you are not entitled to temporary continuation of coverage under COBRA, you may be entitled to temporary coverage under the New York Insurance Law as described below. Call or write your employer or us to find out if you are entitled to

temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

Under New York State law, if you lose coverage because of termination of employment or membership in the class or classes eligible for coverage, you may continue coverage for yourself and your eligible dependents subject to the following conditions:

- A. You are not entitled to Medicare; and you are not covered under or eligible for other group coverage that does not exclude or limit coverage for pre-existing conditions;
 - B. You must request continued coverage within 60 days after the later of: the date of termination; or the date you are given notice of continuation by the group. If you wish continuation under Subparagraph D. (4) below, you must notify the group within 60 days after a determination that you were disabled under the Social Security Act at the time of termination of employment or membership or within the first sixty days of continuation coverage;
 - C. You must pay the premium (not more frequently than monthly) when due. The first payment is due within 60 days after the later of the date coverage would otherwise terminate or the date you are given notice of continuation by the group. The premium cannot exceed 102% of the group's premium rate;
 - D. Coverage will terminate at the earliest of the following:
 - (1) The date 18 months after your coverage would have terminated because of termination of employment or membership;
 - (2) The date to which premiums are paid if you fail to make a timely payment;
 - (3) If you are an eligible dependent, the date 36 months after coverage would have terminated due to: death of the employee or member; divorce or legal separation, the employee or member's eligibility for Medicare; failure to qualify under the definition of "children";
 - (4) The date 29 months after coverage would have otherwise terminated because of termination of employment or membership if the employee or member is determined to have been disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first sixty days of continuation coverage. However, if the employee or member is no longer disabled, coverage will terminate at the later of the date in Subparagraph D. (1) above; or the month that begins more than 31 days after determination that the employee or member is no longer disabled; or
 - (5) The date the group no longer provides coverage to any of its employees or members.
5. **Supplementary Suspension, Continuation And Conversion Rights.** If you, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, and you enter active duty but the group contract holder does not voluntarily maintain your coverage, your coverage shall be suspended unless you elect in writing to the group contract holder, within 60 days of being ordered to active duty, to continue coverage under this Certificate for yourself and eligible dependents. Continued coverage shall not be subject to evidence of insurability. You must pay the required group rate premium in advance to the group contract holder, but not more frequently than once a month.

Supplementary continuation coverage shall not be available to any person who is, or could be, covered by Medicare or any other group coverage. Coverage available through the Federal government for active duty members of the armed forces shall not be considered group coverage for the purposes of this paragraph.

In the event that you are reemployed or restored to participation in the group upon return to civilian status after the period of continuation coverage or suspension, you (and your covered dependents if other than individual coverage applies), shall be entitled to resume coverage under this Certificate. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty provided the applicable premium has been paid from that date. No exclusion or waiting period shall be imposed in connection with resumed coverage except regarding:

- A. A condition that arose during the period of active duty and that has been determined by the secretary of veterans affairs to be a condition incurred in the line of duty; or
- B. A waiting period imposed that had not been completed prior to the period of suspension. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed eleven months.

In the event that you are not reemployed or restored to participation in the group upon return to civilian status, you shall have the right within 31 days of the termination of active duty, or discharge from hospitalization incident to active duty which continues for a period of not more than one year, to submit a written request for continuation to the group, or a request for conversion directly to us, as described elsewhere in this Certificate. Such individual conversion policy shall be effective on the day after the end of the period of supplementary continuation. If other than individual coverage applies and you elect supplementary continuation or if coverage is suspended, the supplementary conversion right shall be available to your spouse if divorce or annulment of the marriage occurs during the period of active duty, and if you die while on active duty, to your spouse and children covered under this Certificate, and to each child individually upon attaining the limiting age of coverage under this Certificate.

The supplementary conversion and continuation rights described above do not apply to you if this Certificate qualifies as an employer group health plan subject to the federal temporary continuation of coverage provisions of COBRA described above. The provisions relating to suspension of coverage shall apply to you even if the conversion and continuation rights do not apply.

SECTION FIFTEEN — RIGHT TO NEW CONTRACT AFTER TERMINATION

You have the right to convert to a new contract if your coverage under this Certificate terminates under the circumstances described below.

1. **Termination Of The Group Contract.** If the Group Contract between us and the group contract holder is terminated as set forth in Section Fourteen, paragraph 1, and the group contract holder has not replaced the coverage for the group with similar and continuous health care coverage, whether insured or self-insured, you are entitled to purchase a new contract as a direct payment member.
2. **If You Are No Longer Covered In A Group.** If your coverage under this Certificate terminates under Section Fourteen, subparagraph 2. B because you are no longer a member of a group, you are entitled to purchase a new contract as a direct payment member.
3. **On The Death Of The Subscriber.** If your coverage under this Certificate terminates under Section Fourteen, subparagraph 2. E because of the death of the Subscriber, you are entitled to purchase a new contract as a direct payment member.
4. **Termination Of Your Marriage.** If your coverage under this Certificate terminates under Section Fourteen, subparagraph 2. F because you become divorced from the Subscriber or your marriage is annulled, you are entitled to purchase a new contract as a direct payment member.
5. **Termination Of Coverage Of A Child.** If your coverage under this Certificate terminates under Section Fourteen, subparagraph 2. G because you no longer qualify as a child, you are entitled to purchase a new contract as a direct payment member.
6. **Termination Of Your Temporary Continuation Of Coverage.** If your coverage under this Certificate terminates under Section Fourteen, paragraph 4 because you are no longer eligible for continuation of coverage, you are entitled to purchase a new contract as a direct payment member.
7. **When To Apply For The New Contract.** If you are entitled to purchase a new contract, as described above, you must apply to us for the new contract within 45 days after termination of your coverage under this Certificate. You must also pay the first premium of the new contract within this same 45-day period.

However, notwithstanding the above, if we determine that you do not reside in New York State, you will not be entitled to purchase a new contract as a direct payment subscriber if:

- A. We determine that similar coverage is available through the local Blue Cross and/or Blue Shield Plan operating in the area in which you are located; and
 - B. The time you were covered under this Certificate will count towards any applicable waiting periods under the available coverage.
8. **The New Contract.** The new contract will be our basic hospital and medical, standard HMO or HMO/POS contract issued upon conversion. However, if you are age 65 or over, the new contract will be one of the contracts issued to Medicare-eligible applicants; or the new contract will be our standard HMO or HMO/POS contract issued upon conversion.

SECTION SIXTEEN — GENERAL PROVISIONS

- 1. **No Assignment.** You cannot assign any benefits or monies due under the Group Contract or this Certificate 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 Certificate or your right to collect money from us for those services.
- 2. **Notice.** Any notice that we give to you under this Certificate will be mailed to your address as it appears on our records or to the address of the group contract holder. If you have to give us 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 Certificate, it may be necessary for us to obtain your medical records and information from Facilities or Professional Providers who treated you. Our 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 Certificate, you automatically give us permission to obtain and use those records for those purposes.

We agree to maintain that information in accordance with state and federal confidentiality requirements. However, you automatically give us permission to share that information with the New York State Department of Health, quality oversight organizations and third parties with which we contract to assist us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

- 4. **Who Receives Payment Under This Certificate.** Payments under this Certificate for service provided by a Participating Provider will be made directly by us to the provider. If you receive services from a Non-Participating Provider, we reserve the right to pay either you or the provider.
- 5. **Time To File Claims.** Claims for services under this Certificate must be submitted to us for payment within 12 months after you receive the services for which payment is being requested.
- 6. **Time To Sue.** No action at law or in equity may be maintained against us prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Certificate. You must start any lawsuit against us under this Certificate within twenty-four months from the date you received the service for which you want us to pay.
- 7. **Venue For Legal Action.** If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against us 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 we bring against you.
- 8. **Choice Of Law.** This Certificate shall be governed by the laws of the State of New York.
- 9. **Recovery Of Overpayments.** On occasion a payment will be made when you are not covered, for a service that is not covered, or which is more than is proper. When this happens we will explain the problem to you and you must return the amount of the overpayment to us within 60 days after receiving notification from us.

10. **Right To Offset.** If we make a claim payment to you or on your behalf in error or you owe us any money, you must repay the amount you owed to us. If we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we owe you.
11. **Continuation Of Benefit Limitations.** Some of the benefits under this Certificate are limited to a specific number of visits and lifetime maximums. 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 dependent to Subscriber, all benefits previously utilized when you were a dependent will be applied toward your new status as a Subscriber.
12. **Subrogation.** In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and we pay benefits as a result of that injury or illness, we will be subrogated and succeed to the right of recovery against the party responsible for your illness or injury to the extent of the benefits we have paid.

Duty to Cooperate with Us — Possible Penalties for Failure to Cooperate. Under certain circumstances, we are also entitled to be reimbursed for the benefits we have paid from a settlement or a judgment you receive from the party responsible for your illness or injury. This and other penalties which apply under certain circumstances are noted below. Those circumstances are:

- A. The settlement or judgment you receive from the party responsible for your illness or injury specifically identifies or allocates monetary sums directly attributable to expenses for which we have paid benefits; or
- B. You fail to cooperate with us in proceeding against the party responsible for your illness or injury to recover the benefits we have paid. We will pay all expenses associated with a legal action instituted on our initiative.

The penalty for failing to cooperate under Subparagraph B above is that you will be responsible to repay to us the amount of the benefits we have paid. We agree to invoke Subparagraph B only when your illness or injury caused by a third party results in our expenditure on your behalf of an amount exceeding \$500 under this coverage. In any of these provisions where we must give our prior written consent, we agree not to unreasonably withhold our prior consent and we agree to waive all penalties under these provisions if we do not give or withhold our prior consent within 30 days from the date you or your legal representative seeks prior consent in writing from us.

13. **Who May Change This Certificate.** The Certificate may not be modified; amended; or changed, except in writing, and signed by our Chief Operating Officer (COO) or a person designated by the COO. No employee; agent; or other person is authorized to interpret; amend; modify; or otherwise change the Certificate 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 or person designated by the COO.
14. **Changes In This Certificate.** We may unilaterally change this Certificate upon the group's renewal, if we give the group contract holder 44 days' prior notice.
15. **Renewal Date.** The renewal date for the Certificate is January 1 of each year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by us or the group contract holder as permitted by the Certificate or by you upon 30 days' prior written notice to the group contract holder.
16. **Agreements Between The Plan And Participating Providers.** Any agreement between us and Participating Providers may only be terminated by us or the providers. This Certificate does not require any provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.
17. **Material Accessibility.** We will give the group contract holder, and the group contract holder will give Members, identification cards, Certificates, Riders and other necessary materials.
18. **Refund.** We will give any refund of premiums, if due, to the group contract holder.

19. **Notice Of Claim.** Claims for services under this Certificate must include all information designated by us 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 will not be accepted and must be resubmitted with all necessary information.
20. **Identification Cards.** Identification cards are issued by us for identification only. Possession of any identification card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits the Member's premiums must be paid in full at the time that the services are sought to be received. Coverage under this Certificate may be terminated by us if the Member allows another person to wrongfully use the identification cards.
21. **Right To Develop Guidelines And Administrative Rules.** We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Certificate. 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 Certificate. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Certificate.
22. **Furnishing Information And Audit.** The group contract holder and all persons covered under this Certificate will promptly furnish us with all information and records that we may require from time to time to perform our obligations under this Certificate. You must provide us with information over the telephone for reasons like the following: to allow us to determine the level of care you need; so that we may certify care authorized by your physician; or to make decisions regarding the Medical Necessity of your care. The group contract holder will, upon reasonable notice, make available to us, and we may audit and make copies of, any and all records relating to group enrollment at the group contract holder's New York office.
23. **Enrollment; ERISA.** The group contract holder further 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 Certificate, and any other information required to confirm their eligibility for coverage. The group contract holder will provide us with the enrollment form including your name, address, age, and social security number and to advise us in writing when you are to be added to or subtracted from our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date the group's contract with us. If the group contract holder fails to so advise us, the group contract holder will be responsible for the cost of any claims paid by us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 30 days.

The group contract holder 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 contract holder, or a third party appointed by the group contract holder. We are not the ERISA plan administrator.

24. **Reports And Records.** We are entitled to receive from any provider of services to Members, information reasonably necessary to administer this Certificate subject to all applicable confidentiality requirements as defined in the General Provisions Section of this Certificate. By accepting coverage under this Certificate, the Member, for himself or herself, and for all covered dependents 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 us or a medical, dental, or mental health professional that we may engage to assist us 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 us, or a medical, dental, or mental health professional, that we may engage to assist us in reviewing a treatment or claim; and

C. Permit copying of the Member's records by us.

25. **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 the obligations created under this agreement.
26. **BlueCard — Calculation Of Member Liability.** Like all Blue Cross and Blue Shield Licensees (hereinafter "Plans"), we participate in a program called the BlueCard Program. This program provides benefits when you are outside our Service Area. When you receive health care services outside our Service Area from a provider that participates with a Blue Cross and Blue Shield Plan, your claims may be processed through the BlueCard Program.

Your liability for BlueCard covered services, if not covered by a flat dollar copayment, will be based on the lower of:

- A. The provider's billed charges; or
- B. The negotiated price that the out-of-area Blue Cross and Blue Shield Plan passes on to us. This negotiated price may be:
- (1) The price the out-of-area Blue Cross and Blue Shield Plan paid its provider; or
 - (2) An estimated price that includes expected settlements, withholds, other payment arrangements, or non-claims transactions with the provider that the out-of-area Blue Cross and Blue Shield Plan factored in; or
 - (3) An average price that includes reductions to the bill that reflects the out-of-area Blue Cross and Blue Shield Plan's average expected savings.

The out-of-area Blue Cross and Blue Shield Plan may increase or decrease the negotiated price in the future to correct for over- or underestimation of past prices. But the amount paid by you will be your final price, and will not be affected by any future adjustment.

Some states may prohibit out-of-area Blue Cross and Blue Shield Plans from passing on to us their entire savings on a particular claim. Other states may require the out-of-area Blue Cross and Blue Shield Plan to add a surcharge to the bill. In either of these events, we would calculate your liability in accordance with the applicable law in effect at the time you received your services.

27. **Grievance Procedures.** We maintain procedures to resolve Member grievances. These procedures make sure that we resolve your questions, concerns, and complaints in a timely, fair manner.
- A. **Filing a Grievance.** Our Grievance Procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by us. To initiate a grievance, just contact us. We keep all requests and discussions confidential and we'll take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry. We maintain a file on each grievance.
- You can either contact our Customer Service Department by phone, in person or in writing to file a grievance. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.
- When we receive your grievance, we'll mail an acknowledgment letter within 15 business days. This acknowledgment letter will include the name, address and telephone number of the person handling your grievance, and indicate what additional information, if any, must be provided.
- We will decide your grievance and notify you of our determination in writing within 30 calendar days of receipt of your grievance request.

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

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

- B. Notice of Determination.** The notice of determination of your grievance will include detailed reasons and, if a clinical matter is involved, the clinical rationale, and further appeal rights, if any. We will send notices to you or your representative and to your health care provider.

If you remain dissatisfied with our grievance determination or at any other time you are dissatisfied, you may:

Call the New York State Department of Insurance at 1-800-342-3736 or write them at:

New York State Department of Insurance
Consumer Services Bureau
One Commerce Plaza
Albany, NY 12257
www.ins.state.ny.us

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

We have developed Utilization Review policies to assist us in administering the Utilization Review program. These policies describe the process and procedures of Utilization Review activities. Reviews are conducted by registered nurses and our Medical Directors. All determinations that services are not Medically Necessary will be made by licensed physicians. We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not or were not Medically Necessary. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review at our office. For more information, you can contact us. Our failure to make a Utilization Review determination within the applicable time frames set forth below shall be deemed an adverse determination subject to an internal appeal.

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

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

With respect to urgent prospective claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 72 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

- B. **Concurrent Reviews.** When you are receiving services that are subject to concurrent review, a nurse will periodically assess the Medical Necessity and appropriateness of care you receive throughout the course of treatment. Once a case is assigned for concurrent review, a nurse will determine whether the services are Medically Necessary. If so, the nurse will authorize the care. If the nurse determines that Medical Necessity is lacking or that further evaluation is needed, the nurse will refer the case to a licensed physician.

Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to your provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision, but no later than 15 calendar days of receipt of the request.

For concurrent reviews that involve urgent matters, we will make a determination and provide notice to you and your provider within 24 hours of receipt of the request.

If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.

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

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

- D. **Notice of Adverse Determination.** A notice of adverse determination (notice that a service is not Medically Necessary) will include the reasons, including clinical rationale, for our determination. The notice will also advise you of your right to appeal our determination, give instructions for requesting an external appeal and for initiating an external appeal and specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal. We will send notices of determination to you or your designee and to your health care provider.

If, prior to making an adverse determination, no attempt was made to consult with the provider who recommended the service at issue, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For prospective and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to the provider, by telephone and in writing.

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

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

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

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review, or any other urgent matter, will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request.

If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal. Our failure to render a determination of your internal appeal within 60 calendar days shall be deemed a reversal of the initial adverse determination.

- F. **Notice of Determination of Internal Appeal.** The notice of determination of your internal appeal will indicate that it is a "final adverse determination" and will include the clinical rationale for our decision. It will also explain your rights to an external appeal, together with a description of the external appeal process and the time frames for initiating an external appeal. We will send notices of determination to you or your designee and to your health care provider.

29. **External Appeal.**

- A. **External Appeal in General.** You have the right to an "external appeal" of certain coverage determinations made by us. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by the State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal. "Requested service" or "requested services" refers to the service or services for which you are requesting coverage.

You may have the right to an expedited external appeal if your attending physician attests that a delay in providing the requested service would pose an imminent or serious threat to your health. The timeframes for expedited external appeals are shorter than the timeframes for standard external appeals.

You may request an external appeal only if the requested service is a covered service under this Certificate.

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

In general, you may not request an external appeal unless we have issued a "final adverse determination" of your request for coverage through the first level of the internal appeal process. You may ask us to agree to an external appeal even though you have not obtained a final adverse

determination through the first level of the internal appeal process; however, we have no obligation to agree to your request. If we do agree, we will send you a letter stating that we have agreed to an external appeal even though you have not obtained a final adverse determination.

To be eligible for external appeal, the final adverse determination issued through the first level of the internal appeal process must be based on a determination that the requested service is not Medically Necessary, or that the requested service is experimental or investigational. You do not have the right to an external appeal of any other determinations, even if those other determinations affect your coverage.

- C. **Conditions for External Appeals of Determinations of Medical Necessity.** You may request an external appeal of a final adverse determination of Medical Necessity issued through the first level of the internal appeal process if you meet the conditions of this subparagraph and the general requirements of Subparagraph B above. The provisions of this subparagraph apply only to external appeal of Medical Necessity determinations.

To request external appeal under this subparagraph, the final adverse determination must indicate that the requested service is not Medically Necessary. Subparagraph G below provides information on requesting an external appeal.

- D. **Conditions for External Appeals of Determinations Involving Experimental or Investigational Treatment.** This subparagraph governs external appeals of determinations involving experimental or investigational treatment. This subparagraph does not govern determinations involving services provided in clinical trials that are governed by Subparagraph E below.

In order to request an external appeal under this subparagraph, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one that, according to the current diagnosis of your attending physician, has a high probability of causing your death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

In addition, your attending physician must certify: that standard health services or procedures have been ineffective, or would be medically inappropriate in treating your life-threatening condition or disease; or, that no more beneficial standard treatment exists which is a covered service under this Certificate.

Your attending physician must have recommended a health service or procedure (including off-label usage of a pharmaceutical product) which, based on at least two documents from the available medical literature, is likely to be more beneficial to you than any standard covered health service or procedure. To make this recommendation, your attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

If you meet the requirements of this subparagraph and all of the requirements of Subparagraph B, you may request an external appeal. Subparagraph G provides information on requesting an external appeal.

- E. **External Appeals of Determinations Involving Clinical Trials.** This subparagraph governs external appeals of determinations involving services provided in clinical trials.

In order to request an external appeal under this subparagraph, your attending physician must certify that you have a life-threatening or disabling condition or disease as described in Subparagraph D above. In addition, your attending physician must certify that a clinical trial for your condition exists and that you are eligible to participate in the clinical trial.

Your attending physician must also recommend that you participate in the clinical trial. To make this recommendation, your attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The clinical trial for which you are requesting coverage must be peer-reviewed, reviewed and approved by a qualified Institutional Review Board, and approved by one of the following:

- (1) The National Institutes of Health (NIH), an NIH cooperative group or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs;
- (2) An entity that has been identified by the NIH as a qualified non-governmental research entity; or
- (3) An Institutional Review Board of a facility that has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

If you meet the requirements of this subparagraph and all of the requirements of Subparagraph B, you may request an external appeal. Subparagraph G below provides information on requesting an external appeal.

F. Effect of the External Appeal Agent's Decision; Coverage. The decision of the External Appeal Agent is binding on both parties. If the External Appeal Agent decides in our favor, we will not cover the requested service. If the external appeal agent decides in your favor, we will cover the service as follows:

- (1) For services denied as not Medically Necessary, we will treat the service as Medically Necessary and provide coverage subject to all other conditions of this Certificate.
- (2) For services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of this Certificate.
- (3) For services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of this Certificate. We are not required to pay for drugs or devices that are the subject of the clinical trial.

We will not provide coverage for any service that is not a covered service under this Certificate. In addition, this subparagraph does not alter any cost-sharing responsibilities as otherwise provided for in this Certificate.

G. Requesting an External Appeal. If you meet the conditions described above, you may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your physician may file an appeal on your behalf. We will send a standard request form to you when we have made a final adverse determination at the first level of the internal appeal process. You or your physician may obtain additional standard request forms at any time from the State Insurance Department, the Department of Health, or by contacting us.

You must file your request for an external appeal with the State Insurance Department within 45 days of receiving a final adverse determination as a result of the first level appeal process, or within 45 days of receiving a letter from us waiving the internal review process. We do not have the authority to grant extensions of this deadline.

Additional internal appeals may be available to you which are optional. However, regardless of whether you participate in additional internal appeals, your application for external appeal must be filed with the New York State Department of Insurance within 45 days from your receipt of the notice

of final adverse determination from a first level internal appeal in order to be eligible for review by an external appeal agent.

You may be charged a fee of up to \$50 to request an external appeal, which may be waived if we determine that paying the fee is a financial hardship. The fee is returned if your external appeal is successful.

If you do not understand any part of the external appeal process or if you have questions regarding your right to external appeal, you may contact us, the State Insurance Department, or the Department of Health.



This is your
BASIC MEDICAL CERTIFICATE OF COVERAGE

Issued by
EXCELLUS HEALTH PLAN, INC.
A nonprofit independent licensee of the BlueCross BlueShield Association

This Certificate of Coverage ("Certificate") explains the benefits available to you under a Group Contract between Excellus Health Plan, Inc. (hereinafter referred to as "we", "us", "our", or "the Plan") and the group contract holder listed in the Group Contract. This Certificate is not a contract between you and us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer

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SECTION ONE — INTRODUCTION AND DEFINITIONS

1. **Your Coverage Under This Certificate.** Your employer or organization (referred to as the "group contract holder") has purchased a group health insurance contract from us. Under that contract we will provide the benefits described in this Certificate to members of the group, that is, to employees of the employer or to members of the organization and their covered dependents. However, this Certificate is not a contract between you and us. You should keep this Certificate with your other important papers so that it is available for your future reference.
2. **Definitions.**
 - A. **Allowable Expense.** "Allowable Expense" means the maximum amount we will pay to a Professional Provider for the services or supplies covered under this Certificate. We determine our Allowable Expense as follows:
 - (1) The Allowable Expense for covered services received from Participating Professional Providers will be the amount we have negotiated with the provider or the amount approved by another Blue Cross and Blue Shield Plan; and the Allowable Expense for Non-Participating Providers will be the lower of: the national Medicare fee schedule amount for the Calendar Year prior to the Calendar Year in which the services are rendered; or the provider's charge.
 - (2) The Allowable Expense for services rendered by Non-Participating Providers in connection with an Emergency Condition is the provider's charge.
 - B. **Biologically-Based Mental Illness.** A mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Biologically-based mental illnesses are defined as the following:
 - (1) Schizophrenia/psychotic disorders;
 - (2) Major depression;
 - (3) Bipolar disorder;
 - (4) Delusional disorders;
 - (5) Panic disorder;
 - (6) Obsessive compulsive disorder;
 - (7) Bulimia; and
 - (8) Anorexia.
 - C. **Calendar Year.** The 12-month period beginning on January 1 and ending on December 31. However, if you were not covered under this Certificate for this entire period, Calendar Year means the period from the date you became covered until December 31.
 - D. **Children with Serious Emotional Disturbances.** Persons under the age of 18 years who have diagnoses of attention deficit disorders, disruptive behavior disorders or pervasive development disorders, and where one or more of the following are present:
 - (1) Serious suicidal symptoms or other life-threatening self-destructive behaviors;
 - (2) Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
 - (3) Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or
 - (4) Behavior caused by emotional disturbances that placed the child at significant risk of removal from the household.

- E. **Effective Date.** The date your coverage under this Certificate begins. Coverage begins at 12:01 a.m. on the Effective Date.
- F. **Emergency Condition.** A medical or behavioral condition, the onset of which is sudden and that manifests itself by symptoms of sufficient severity, including 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:
- (1) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or
 - (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 we consider to be Emergency Conditions are heart attacks, poisoning and multiple trauma.

Examples of conditions we do not ordinarily consider to be Emergency Conditions are head colds, flu, minor cuts and bruises, muscle strain and hemorrhoids.

- G. **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; an institutional provider of mental health or chemical dependence and abuse treatment operating under Article 31 of the New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or other provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable). If you receive treatment for chemical dependence or abuse outside of New York State, the Facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") to provide a chemical abuse treatment program.
- H. **Hospital.** Any short-term acute general hospital facility that is accredited as a hospital by JCAHO; is certified under Medicare; and if located in New York State, is licensed pursuant to Article 28 of the Public Health Law of New York. A Hospital is a licensed institution primarily engaged in providing:
- (1) Inpatient diagnostic and therapeutic services for surgical and medical diagnosis;
 - (2) Treatment and care of injured and sick persons by or under the supervision of physicians; and
 - (3) Twenty-four (24) hour nursing service by or under the supervision of registered nurses.

None of the following are considered Hospitals:

- (1) Hospitals for treatment of mental illness. If you are a patient in a separate division or unit of a Hospital dedicated to the treatment of mental illness where the average length of stay is more than 30 days, that separate division or unit is not considered a Hospital;
- (2) Places primarily for nursing care;
- (3) Skilled Nursing Facilities;
- (4) Convalescent homes or similar institutions;
- (5) Institutions primarily for: custodial care; rest; or as domiciles;
- (6) Health resorts; spas; or sanitariums;
- (7) Infirmarys at schools; colleges; or camps;
- (8) Places primarily for the treatment of chemical dependence and abuse; hospice care; or rehabilitation;

- (9) Free standing ambulatory surgical centers.
- I. **Medical Director.** The person designated by us to monitor quality of care and appropriate utilization of health services.
- J. **Medical Necessity.** See Section Three.
- K. **Member.** Any Subscriber or eligible dependent who meets all applicable eligibility requirements, for whom the required premium payment has actually been received by us, and who is covered under this Certificate.
- L. **Mental Illness.** A mental, nervous or emotional condition that we determine has treatable behavioral manifestations and that we also determine:
- (1) Is a clinically significant alteration in thinking, mood or behavior, or a combination thereof; and
 - (2) Substantially or materially impairs your ability to function in one or more major life activities; and
 - (3) Has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
- M. **Non-Participating Provider.** A Facility or Professional Provider that does not have a provider agreement with us or any other Blue Cross and/or Blue Shield Plan to provide health services to Members.
- N. **Participating Provider.** A Facility or Professional Provider that has a provider agreement with us or any other Blue Cross and/or Blue Shield Plan to provide health services to Members. We have provider directories that list all of our Participating Providers. Copies of the directory are issued on enrollment and are available free of charge upon request.
- O. **Professional Provider.** A certified and licensed physician; osteopath; dentist; optometrist; chiropractor; registered psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; licensed midwife; speech-language pathologist; audiologist; or any other licensed health care provider that the New York State Insurance Law requires to be recognized who charges and bills patients for services. Professional Providers also include: independent clinical laboratories; and independent imaging providers.
- P. **Service Area.** The geographic area in which we provide benefits to our Members. Our Service Area consists of the following counties: Monroe; Wayne; Livingston; Seneca; Yates; and Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson.
- Q. **Skilled Care.** A service that we determine 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.
- R. **Skilled Nursing Facility.** A facility accredited as a Skilled Nursing Facility by JCAHO or qualified as a Skilled Nursing Facility under Medicare. We will provide coverage for your care in a Skilled Nursing Facility under a Rider to this Certificate only if we determine that the care is Skilled Care.
- S. **Subscriber.** The member of the group to whom this Certificate is issued.
- T. **"We", "Us", "Our" or "The Plan" and "You", "Your" and "Yours".** Throughout this Certificate, Excellus Health Plan, Inc. will be referred to as "we", "us", "our" or "the Plan". The word "you", "your" or "yours" refers to you, the Subscriber. If other than individual coverage applies, then

in most cases the word "you" also includes any family members who are covered under this Certificate.

SECTION TWO — WHO IS COVERED

1. **Who Is Covered Under This Certificate.** Subject to the permissible eligibility rules of the group contract holder, you, the Subscriber to whom this Certificate is issued, are covered under this Certificate. If you selected other than individual coverage, the following members of your family may also be covered:
 - A. Your spouse, unless you are divorced or your marriage has been annulled.
 - B. Your unmarried children who are under 19 years of age and who are chiefly dependent on you for support.
 - C. Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age at which the child's coverage under this Certificate would otherwise have terminated. The child's disability must be certified by a physician. You must file an application in the form we approve to request that the child be included in your family coverage. We have the right to check whether a child is and continues to qualify under this paragraph. (See Section Ten for when coverage terminates.)

We have the right to request, and have furnished to us, such proof as may be needed to determine eligibility status of a prospective Subscriber and all prospective dependents as they pertain to eligibility for coverage under this Certificate.

2. **Other Children Covered Under This Certificate.** In addition to your natural children, the following other children may also be covered under this Certificate if the child meets the above eligibility requirements for children covered under this Certificate:
 - A. A legally adopted child;
 - B. A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order;
 - C. A stepchild who is chiefly dependent upon you for support; and
 - D. A child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption becoming final.

We have the right to request, and have furnished to us, such proof as may be needed to determine whether a child qualifies as a dependent for purposes of coverage under this Certificate.

3. **Newborn Child.** If you have a type of coverage that would cover a newborn, your newborn child will be covered at birth, provided you notify us within 30 days of the birth by completing the enrollment form to add the child to your coverage. If you are changing your type of coverage (for example from individual to family coverage) in order to cover the newborn child, you must complete the enrollment form to extend your coverage to include your child within 30 days of the birth. If you do not complete the form within 30 days of the birth, coverage of the child will not become effective until the next premium due date after we receive the application. If a child of yours who is covered under this Certificate gives birth, your newborn grandchild will not be covered (unless any of the criteria of Paragraph 2 above apply).
4. **Adopted Newborns.** If you have a type of coverage that will cover a newborn, or switch to a type of coverage that will cover a newborn, in accordance with Paragraph 3 above, we will cover a proposed adoptive newborn from the moment of birth if you (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the Hospital after birth and you file a petition within 30 days of the infant's birth pursuant to §115-C of the New York State Domestic Relations Law or a comparable provision when the child is adopted in another state. However, we will not provide coverage for the initial Hospital stay of an adopted newborn if one of the child's natural parents has coverage

available to cover the newborn's initial Hospital stay. We will also not provide coverage for the newborn if a notice of revocation of the adoption has been filed or one of the natural parents revokes consent to the adoption. If we provide coverage of an adopted newborn and notice of the revocation of the adoption is filed or one of the natural parents revokes their consent, we will be entitled to recover any sums paid by us for care of the adopted newborn.

5. **Types Of Coverage Other Than Individual Coverage.** We offer different types of coverage in addition to individual coverage:
- A. Family Coverage — If family coverage applies, then you, the Subscriber, and your spouse and your children as described above are covered.
 - B. Spousal Coverage — If spousal coverage applies, then only you, the Subscriber, and your spouse as described above are covered.
 - C. Child Coverage — If child coverage applies, then you, the Subscriber, and your child or children as described above are covered.
 - D. Two-Person Coverage — If two-person coverage applies, then you, the Subscriber, and your spouse or one child as described above are covered. You may only select two-person coverage if your family unit consists of two people.

The names of all persons covered under this Certificate must have been specified on the enrollment form for this Certificate or provided to us as described in Paragraph 8 below. No one else can be substituted for those persons. We have administrative rules to determine which types of coverage are available to members of your group. You are only entitled to the types of coverage for which we receive premium and that our records indicate is applicable. You may call us if you have any questions about which type of coverage applies to you.

6. **When Coverage Begins.** Coverage under this Certificate will begin as follows:
- A. If you, the Subscriber, 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 Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible, you must wait until the group's next open enrollment period, except as provided in Paragraph 7 below. When you enroll during the next open enrollment period, coverage then begins at 12:01 a.m. on the date to which the open enrollment period applies.
 - C. If you, the Subscriber, marry while covered, and we receive notice of such marriage within 30 days thereafter, coverage for your spouse starts at 12:01 a.m. on the date of your marriage. If we do not receive notice of the marriage within the 30-day period, your spouse must wait until the next open enrollment period for coverage. When your spouse is enrolled during the next open enrollment period, coverage for your spouse will start at 12:01 a.m. on the date to which the open enrollment period applies.
7. **When You Reject Initial Enrollment Or Elect Not To Enroll During Open Enrollment, But Do Not Need To Wait Until The Group's Next Open Enrollment Period To Enroll For Coverage.** If you, the Subscriber, reject initial enrollment under this Certificate, or elect not to enroll during a subsequent open enrollment, you may enroll for coverage if the following conditions are met:
- A. You or your spouse 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 spouse lost eligibility for one or more of the following reasons:
 - (1) Termination of employment;
 - (2) Termination of the other plan or contract;

- (3) Death of the spouse;
 - (4) Legal separation, divorce or annulment;
 - (5) Reduction in the number of hours worked;
 - (6) The employer or other group ceased its contribution toward the premium for the other plan or contract;
 - (7) The coverage was under an HMO, and you no longer live, work or reside in the HMO service area;
 - (8) Cessation of dependent child status;
 - (9) Benefits are no longer offered to similarly situated individuals (e.g., part-time employees);
 - (10) The benefit maximum under the plan or contract has been reached; or
- C. You acquire a dependent due to birth, adoption, guardianship, placement for adoption or marriage, in which case you, the Subscriber, may enroll for individual coverage or for a type of coverage available to your group that will cover you and your eligible dependents.
- D. You apply for coverage under this Certificate within 30 days after: termination for one of the reasons set forth in Subparagraph B above; or acquisition of a dependent as set forth in Subparagraph C above.

If you enroll for coverage pursuant to Subparagraphs A and B above, your coverage will begin at 12:01 a.m. on the date of the loss of coverage. 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.

8. 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 (other than a newborn child added under Paragraph 3 or 4 above), you must complete and return to us a form for this purpose and any requested documentation. The addition of a spouse or child will be effective as of the date of marriage, adoption or other event making the child eligible for coverage under Paragraph 2, if you return to us a completed application and requested documents within 30 days of the wedding, adoption or other event, and the applicable premium is paid. If you do not return a completed form and documentation within 30 days, your spouse or child will be added to your coverage after the next open enrollment period, so long as the applicable premium is paid.
- B. **When Coverage of a Spouse or Child Terminates.** If you have other than individual coverage, you should notify us of any event that affects your coverage, such as: your divorce, the death of your spouse or Medicare eligibility; or a child marrying, leaving school, reaching the age at which coverage terminates or otherwise experiencing an event that would normally result in termination of dependent coverage. We will provide you with a form for that purpose. If such change results in you seeking a different type of coverage at a lower premium (such as a switch to individual coverage), the form and requested documentation must be returned within 30 days of the event in order for the change in premium to be effective on the date of the event. If you do not return a completed form and any requested documentation within 30 days of the event, the change in premium will be effective as of the next premium due date after they are received. Nothing in this Subparagraph B is designed to affect the provisions of Section Ten governing terminations of coverage. This Subparagraph B only involves the effective date of changes in premiums due to terminations of coverage under Section Ten.

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

SECTION THREE — MEDICAL NECESSITY

1. **Care Must Be Medically Necessary.** We will provide coverage under this Certificate for the covered benefits described in this Certificate 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 we have to provide coverage for it.

We will decide whether a Service was Medically Necessary. We will base our decision in part on a review of your medical records. We will also evaluate medical opinions we receive. 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, we will also consider:

- A. Reports in peer reviewed medical literature;
- B. Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- C. Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care or treatment;
- D. The opinion of health professionals in the generally recognized health specialty involved;
- E. The opinion of the attending Professional Providers, which have credence but do not overrule contrary opinions; and
- F. Any other relevant information brought to our attention.

Services will be deemed Medically Necessary only if:

- A. They are clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease;
 - B. They are required for the direct care and treatment or management of that condition;
 - C. If not provided, your condition would be adversely affected;
 - D. They are provided in accordance with generally-accepted standards of medical practice;
 - E. They are not primarily for the convenience of you, your family, the Professional Provider or another provider;
 - F. They are not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease; and
 - G. When you are an inpatient, your medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided to you in any other setting (e.g., outpatient, physician's office or at home).
2. **Service Must Be Approved Standard Treatment.** Except as otherwise required by law, no Service rendered to you will be considered Medically Necessary unless we determine that the Service is consistent with the diagnosis and treatment of your medical condition; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative. Please see Section Twelve, paragraph 29 for your right to an external appeal of our determination that a Service is not Medically Necessary.

SECTION FOUR — PROFESSIONAL SERVICES

We will provide coverage for the services of Professional Providers described below.

1. **Surgery.** Surgery includes operative procedures for the treatment of disease or injury. It includes any pre and post-operative care usually rendered in connection with such procedures. Pre-operative care includes pre-operative examinations that result in a decision to operate. Surgery also includes endoscopic procedures and the care of fractures and dislocations of bones. We will provide coverage for screening colonoscopies.

We will also provide coverage for surgical services including all stages of reconstructive surgery on a breast on which a mastectomy has been performed. We 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.** We will provide coverage for surgical procedures performed while you are an inpatient in a Hospital or other Facility.
 - B. **Outpatient Surgery.** We 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.
 - C. **Office Surgery.** We will provide coverage for surgical procedures performed in the Professional Provider's office.
2. **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. We will not provide coverage for the administration of anesthesia for a procedure not covered by this Certificate.
 3. **Additional Surgical Opinions.** We will provide coverage for a second opinion, or a third opinion if the first two opinions do not agree, with respect to proposed surgery subject to all the following conditions:
 - A. You seek the second or third surgical opinion after your surgeon determines your need for surgery.
 - B. The second or third surgical opinion is rendered by a physician:
 - (1) Who is a board certified specialist; and
 - (2) Who, by reason of his or her specialty, is an appropriate physician to consider the proposed surgical procedure.
 - C. The second or third surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under this Certificate if such surgery was performed.
 - D. You are examined in person by the physician rendering the second or third surgical opinion.
 - E. The specialist who renders the opinion does not also perform the surgery.
 4. **Second Medical Opinions.** We 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. We 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 the benefits available for services of Participating Providers when you receive services from a Non-Participating Professional Provider.
 5. **Maternity Care.** We 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 another state.
- B. **Complications of Pregnancy and Termination.** We will provide coverage for complications of pregnancy and for termination of pregnancy, including elective termination of pregnancy.
- C. **Anesthesia.** We will provide coverage for delivery anesthesia.

6. **Inpatient Services.**

- A. **Medical Care.** We will provide coverage for medical visits by a Professional Provider on any of the unlimited days inpatient care covered under your Basic Hospital Certificate of Coverage. We will not provide coverage for medical visits by Facility employees or interns, even if they are Professional Providers.

The Professional Provider's services must be documented in the Facility records. We 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.

- B. **Mental Health Care.** We will provide coverage for visits by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of section 4303 (n) of the New York Insurance Law, a professional corporation or a university faculty practice corporation, for diagnosis and treatment of Mental Illnesses on any day of active treatment or equivalent days of treatment in a partial hospitalization program covered under your Basic Hospital Certificate of Coverage.

The provider's services must be documented in the facility records.

7. **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.** We 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.** We will provide coverage for periodic adult routine physical examinations in accordance with a schedule based on national coverage determinations, but not to exceed one examination per Member, per Calendar Year. We will also provide coverage for any laboratory, pathology, x-ray or other imaging services provided in connection with the routine examination.
 - (2) **Well Child Visits and Immunizations.** We will provide coverage for well child visits in accordance with the schedule recommended by the American Academy of Pediatrics. We will also cover childhood immunizations recommended by the Advisory Committee on Immunization Practices ("ACIP"), in accordance with the ACIP recommended schedule.

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

- B. **Laboratory and Pathology Services.** We will provide coverage for diagnostic and routine laboratory and pathology services.

8. **Diagnostic And Routine Imaging Examinations And Diagnostic Radioactive Isotope Procedures.** Subject to the provisions below, we will provide coverage for the professional component of the following procedures, when rendered and billed by a Professional Provider: x-ray examinations; radioactive isotope; ultrasound; computerized axial tomography (CAT) scan; PET scan; and MRI.

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

9. **Radiation Therapy And Chemotherapy.** We will provide coverage for radiation therapy and chemotherapy.
10. **Hemodialysis.** We will provide coverage for hemodialysis treatments of an acute or chronic kidney ailment.
11. **Mammography Screenings.** We will provide coverage for mammography screenings for occult breast cancer according to our preventive care guidelines. At a minimum, our coverage will be as follows:
- A. **Women at Risk.** We will provide coverage for mammograms for women of any age who have a prior history of breast cancer or who have a first degree relative (such as a child, mother or sister) or a maternal or paternal grandmother who has a prior history of breast cancer, if the mammogram is recommended by a physician.
 - B. **Women 35 through 39 Years of Age.** We will provide coverage for one baseline mammogram for women 35 through 39 years of age.
 - C. **Women 40 Years of Age and Older.** We will provide coverage for one mammogram in each Calendar Year for women 40 years of age and older.

Mammography screening includes, but is not limited to, an x-ray examination of the breast using dedicated equipment, including x-ray tube; filter; compression device; screens; films; and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

12. **Routine Gynecological Services.** We will provide coverage for routine gynecology visits. This includes coverage for screening for cervical cancer and its precursor states for women 18 years of age and older, or for younger women who are sexually active, according to our preventive care guidelines. At a minimum, we will provide coverage for one screening each Calendar Year for women age 18 and older. 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.
13. **Screenings For Prostate Cancer.** We will provide coverage for diagnostic screenings for prostate cancer, including standard diagnostic testing and standard diagnostic exams, according to our preventive care guidelines. At a minimum, we will provide coverage for prostate screenings as follows:
- A. **Men with a Prior History of Prostate Cancer.** We will provide coverage for standard diagnostic testing for men of any age who have had a prior history of prostate cancer.
 - B. **Men at Risk.** We will provide coverage for one standard diagnostic exam in each Calendar Year for men over the age of 40 who have a family history of prostate cancer or who have other risk factors for prostate cancer.
 - C. **Men 50 Years of Age or Older.** We will provide coverage for one standard diagnostic exam in each Calendar Year for men 50 years of age and older.

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

14. **Mental Health Care.** We will provide benefits for up to 20 visits in a Calendar Year for diagnosis and treatment of Mental Illnesses provided by a: psychiatrist or psychologist licensed to practice in this state; licensed clinical social worker who meets the requirements of section 4303 (n) of the New York Insurance Law; professional corporation; or university faculty practice corporation.

Services provided in a facility pursuant to your Basic Hospital Certificate of Coverage and in a practitioner's office pursuant to this section are subject to the visit limit above.

Services of Participating and Non-Participating Providers will both be counted toward this 20-visit maximum.

The coverage described above includes benefits for Biologically-Based Mental Illness and for Children with Serious Emotional Disturbances; however, benefits for Biologically-Based Mental Illness and Children with Serious Emotional Disturbances are not subject to the 20-visit limit set forth above. We will provide coverage for all Medically Necessary visits for these conditions.

15. **Inpatient Consultations.** We 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.
16. **Infertility Treatment Services.** We will provide coverage for Medically Necessary services for the diagnosis and treatment of infertility subject to the following conditions:
- A. **Infertility Defined.** For the purposes of this paragraph, infertility has the meaning set forth in the regulations of the New York State Insurance Department. In general, infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse.
 - B. **Coverage Provided for Individuals 21 to 44 Years of Age.** The benefits provided by this paragraph are available only to Members covered under this Certificate who are between the ages of 21 and 44 as of the date the services are rendered.
 - C. **Coverage Only Provided for Appropriate Candidates.** Coverage under this paragraph will only be provided to "Appropriate Candidates" within the age group described in Subparagraph B. An Appropriate Candidate is an individual determined to be an Appropriate Candidate by the treating physician, in accordance with the standards and guidelines established and adopted by the New York State Insurance Department by regulation.
 - D. **Covered Services.** Subject to the other provisions of this paragraph and your Certificate, we will provide benefits under this paragraph for:
 - (1) Medical and surgical procedures, such as artificial insemination, intrauterine insemination, and dilation and curettage ("D & C"), that would correct malformation, disease or dysfunction resulting in infertility; and
 - (2) Services in relation to diagnostic tests and procedures necessary:
 - (a) To determine infertility; or

(b) In connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered by this paragraph are:

- (i) Hysterosalpingogram;
- (ii) Hysteroscopy;
- (iii) Endometrial biopsy;
- (iv) Laparoscopy;
- (v) Sono-hysterogram;
- (vi) Post-coital tests;
- (vii) Testis biopsy;
- (viii) Semen analysis;
- (ix) Blood tests;
- (x) Ultrasound; and
- (xi) Other Medically Necessary diagnostic tests and procedures, unless excluded by law.

E. **Plan of Care Required.** All services covered under this paragraph must be prescribed by a physician as part of a "plan of care." The plan of care must be in writing, and must be available for review by us. Services or procedures that are inconsistent with or not included in the plan of care will not be covered.

F. **Services Must be Received from Eligible Providers.** Services covered by this paragraph must be received from "Eligible Providers" as determined by us in accordance with applicable regulations of the New York State Insurance Department. In general, an Eligible Provider is defined as a health care provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine.

G. **Excluded Services.** We will not pay benefits for the following reproductive procedures or services:

- (1) In-Vitro Fertilization;
- (2) Gamete Intra-Fallopian Transfer (GIFT);
- (3) Zygote Intra-Fallopian Transfer (ZIFT);
- (4) Reversal of elective sterilizations, including vasectomies and tubal ligations;
- (5) Sex change procedures;
- (6) Cloning;
- (7) Sperm banking and donor fees associated with artificial insemination or other procedures;
- (8) Other procedures or categories of procedures excluded by statute.

H. **Experimental Procedures Not Covered.** This paragraph does not cover services or procedures that we, in our sole judgment, determine to be experimental, according to standards and guidelines that are no less favorable than those established and adopted by the American Society for Reproductive Medicine. You may appeal our determination that a service or procedure is experimental to an external appeal agent as described in Section Twelve, paragraph 29.

17. **Mastectomy Care.** In addition to the surgical services covered under Paragraph 1 above, we will also provide coverage for prostheses and treatment of physical complications of a mastectomy, including lymphedemas.

18. **Benefits For Professional Services.**

Participating Providers. Services of Participating Providers are covered at 100% of the Allowable Expense.

Non-Participating Providers. Services of Non-Participating Providers are covered at 100% of the Allowable Expense.

19. **Individual Case Management.**

- A. **Alternative Benefits.** If you agree to participate and abide by our policies, in addition to benefits specified in this Certificate, we may provide, outside the terms of this Certificate, benefits for services, for up to a 60-day period, furnished by any Participating Provider pursuant to the alternative treatment plan of ours for a Member whose condition would otherwise require hospitalization.

We may provide such alternative benefits if and only for so long as we determine, 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 Certificate in the absence of alternative benefits.

If we elect to provide alternative benefits for a Member in one instance, it shall not obligate us 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 our right to administer this Certificate thereafter in strict accordance with its expressed terms.

At the expiration of such 60-day period, you may apply in writing for a continuation of the alternative benefits and services being provided outside the terms of this Certificate. Upon such application for renewal, we will review the patient's condition and may agree to a renewal of such alternative benefits and services. Renewals must be in writing and our determination will be final.

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

- B. **Appeals of Individual Case Management.** If we deny 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 our Member Services Department at the phone number located on your identification card.

SECTION FIVE — EMERGENCY CARE

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

1. **Eligibility For Benefits.** We will provide coverage for medical visits of Professional Providers who are not Facility employees or interns to treat an Emergency Condition in an emergency room or freestanding urgent care center.

When you make visits to the emergency room for a condition that is not an Emergency Condition, you will be liable for the entire charge for the visit including all associated charges of Professional Providers.

2. **Benefits For Emergency Care.**

Participating Providers. Services of Participating Providers are covered at 100% of the Allowable Expense.

Non-Participating Providers. Services of Non-Participating Providers are covered at 100% of the Allowable Expense.

SECTION SIX — HUMAN ORGAN AND BONE MARROW TRANSPLANTS

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

1. **Prior Approval Required.** All organ transplants must be pre-approved by us. You or your Professional Provider must call us 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 us within 24 hours after your admission or as soon thereafter as reasonably possible. If you fail to seek our prior approval for an organ transplant, we will provide coverage for an amount \$500 less than we would otherwise cover for the care, or we will provide coverage for only 50% of the amount we would otherwise have covered for the care, whichever results in a greater benefit to you. You must pay the remaining charges. We will provide coverage for the amount specified above only if we determine the care was Medically Necessary even though you did not seek our prior approval. If we determine, 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 transplant centers certified or otherwise approved by the appropriate regulatory authority for the specific type of transplant procedure being performed. The types of organ transplants that must be performed in certified transplant centers are: bone marrow; liver; heart; lung; heart-lung; kidney; and kidney-pancreas. You may contact us if you wish to obtain a list of certified transplant centers.
3. **No Coverage Of Experimental Or Investigational Organ Transplants.** We will not provide coverage for any benefits for an organ transplant we determine to be experimental or investigational. We maintain and revise from time to time a list of organ transplant procedures which we determine not to be experimental or investigational and therefore are covered under this Certificate. You may contact us if you have a question concerning whether a particular transplant procedure is covered. See Section Twelve, paragraph 29 for your right to an external appeal of our determination that an organ transplant is experimental or investigational.
4. **Recipient Benefits.** We will provide coverage for a person covered under this Certificate for all of the benefits provided to the recipient of the organ transplant that are otherwise covered under this Certificate when they result from or are directly related to a covered organ or bone marrow transplant.
5. **Coverage For Donor Searches Or Screenings.** We will not provide coverage for costs relating to searches or screenings for donors of organs.
6. **Costs Of Organ Donor.** We will provide coverage for the medical services directly related to the donation of an organ for transplantation to a person covered under this Certificate. We will not provide coverage if you are donating an organ for transplantation to a person not covered under this Certificate.

SECTION SEVEN — EXCLUSIONS

In addition to the exclusions and limitations described in other sections of this Certificate, we will not provide coverage for the following:

1. **Acupuncture.** We will not provide coverage for any service or care related to acupuncture treatment and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery.
2. **Blood Products.** We 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.

3. **Certification Examinations.** We 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.
4. **Contraceptive Drugs And Devices.** We will not provide coverage for any service or care related to contraceptive drugs or devices, including, but not limited to, family planning services, implantable drugs, intra-uterine devices and diaphragms.
5. **Cosmetic Services.** We 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 we often determine to be not Medically Necessary include the following: breast enlargement, rhinoplasty and hair transplants. We 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. We will also provide coverage for reconstructive surgery because of congenital disease or anomaly of a child covered under this Certificate that has resulted in a functional defect. We will also provide coverage for services in connection with reconstructive surgery following a mastectomy, as provided in Section Four.
6. **Court-Ordered Services.** We 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 Certificate in the absence of a court order;
 - B. Our 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 Certificate.

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

7. **Criminal Behavior.** We 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.
8. **Custodial Care.** We will not provide coverage for any service or care that is custodial in nature, or any therapy that we determine is not expected to improve your condition. Care is considered custodial when it is primarily for the purpose of meeting personal needs and includes activities of daily living such as help in transferring, bathing, dressing, eating, toileting, and such other related activities.
9. **Dental Care.** We will not provide coverage for any service or care (including anesthesia and inpatient stays) for treatment of the teeth, gums, or structures supporting the teeth; or any form of dental surgery; regardless of the reasons(s) that the service or care is necessary. For example, we will not provide coverage for x-rays, fillings, extractions, braces, prosthetics, correction of impactions, treatments for gum disease, therapy or other treatments related to dental TMJ disorder or dental oral surgery. We 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. In addition, we will provide the benefits set forth in this Certificate for service and care for treatment of sound natural teeth provided within 12 months of an accidental injury. We do not consider an injury to a tooth caused by chewing or biting to be an accidental injury. We will also provide coverage for the services set forth in this Certificate that we determine are Medically Necessary for treatment of a congenital anomaly or disease that was evident and observable at birth and caused by a medical condition that was present at birth. We will also provide coverage for the services set forth in this Certificate that we determine are Medically Necessary for treatment of cleft palate and ectodermal dysplasia.

10. **Developmental Delay.** We will not provide coverage for educational services related to evaluation, testing and treatment of behavioral disorders, learning disabilities, minimal brain dysfunction, development and learning disorders, or developmental delays. We will also not provide benefits for any covered service or care set forth in this Certificate when rendered in connection with such conditions, unless Medically Necessary.
11. **Durable Medical Equipment; Prosthetic Devices; Medical Supplies; Disposable Supplies; Hair Prosthetics; Household Fixtures.** We will not provide coverage for any service or care related to:
- A. The rental, purchase, repair, or maintenance of durable medical equipment (for example, respirators, canes, crutches, walkers, wheelchairs, trusses, apnea monitors, oxygen-related equipment, special hospital-type beds, or home dialysis units);
 - B. Prosthetic devices (except as set forth in Section Four, paragraph 16), (for example, artificial arms, legs and eyes, and ostomy bags and supplies required for their use);
 - C. Medical supplies (for example, bandages, surgical gloves and compression stockings);
 - D. Disposable supplies (for example, diapers, chux, sponges, syringes, incontinence pads, reagent strips and bandages purchased for general use);
 - E. Wigs, hair prosthetics, or hair implants;
 - F. Orthotics, including, but not limited to, custom-made shoes and arch supports; and
 - G. The purchase or rental of household fixtures, including, but not limited to, elevators, escalators, ramps, seat lift chairs, stair glides, saunas, whirlpool baths, swimming pools, home tracking systems, exercise cycles, air or water purifiers, hypo-allergenic pillows, mattresses or waterbeds, massage equipment, central or unit air conditioners, humidifiers, dehumidifiers, emergency alert equipment, handrails, heat appliances, improvements made to a house or place of business, and adjustments made to vehicles.
12. **Reversal Of Elective Sterilization.** We will not provide coverage for any service or care related to the reversal of elective sterilization.
13. **Experimental And Investigational Services.** Unless otherwise required by law, we 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 we determine that the Service is experimental or investigational. See Section Twelve, paragraph 29 for your right to an external appeal of our determination that a Service is experimental or investigational.

"Experimental or investigational" means that we determine 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, we may, in our 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 Certificate 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.

- 14. **Free Care.** We 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 Certificate. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your spouse, brother, sister, mother, father, son or daughter; or the spouse of any of them; we will presume that the service or care would have been furnished without charge. You must prove to us that a service or care would not have been furnished without charge.
- 15. **Government Hospitals.** Except as otherwise required by law, we will not provide coverage for any service or care you receive in a Facility or institution which is owned, operated or maintained by: the Veterans Administration (VA); a federal, state, or local government, unless the Facility is a Participating Provider. However, we will provide coverage for services or care in such a Facility to treat an Emergency Condition. In this case, we will continue to provide coverage only for as long as we determine that emergency care is necessary and it is not possible for you to be transferred to another Facility.
- 16. **Government Programs.** Except as provided below when you are covered under Medicare, we will not provide coverage for any service or care for which benefits are payable under any federal, state, or local government program, except when required by state or federal law. When you are covered under Medicare, and Medicare is primary according to federal law, Medicare benefits and the benefits under this Certificate will be coordinated as set forth in Section Nine.

According to federal law, Medicare is not primary 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 Subscriber is in "current employment status" (working actively and not retired) with the group contract holder; and

- (2) The Subscriber's employer maintains or participates in an employer group health plan that is required by law to have this Certificate 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 Subscriber is in "current employment status" (working actively and not retired) with the group contract holder; and
 - (2) The Subscriber's employer maintains or participates in a large group health plan, as defined by law, that is required by law to have this Certificate 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. During the waiting period, benefits under this Certificate are primary. We will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before we provide benefits under this Certificate.
17. **Hypnosis/Biofeedback.** We will not provide coverage for hypnosis or biofeedback.
 18. **Military Service-Connected Conditions.** We will not provide coverage for any service or care related to any military service-connected disability or condition, if the Veterans Administration (VA) has the responsibility to provide the service or care.
 19. **No-Fault Automobile Insurance.** We 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. We will provide benefits for services covered under this Certificate 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, we will provide coverage for the services covered under this Certificate, up to the amount of the deductible. We will not provide benefits even if you bring a lawsuit against the person who caused your injury and even if you receive money from that lawsuit and you have repaid the medical expenses you received payment for under the mandatory automobile no-fault coverage.
 20. **Non-Covered Service.** We will not provide coverage for any service or care that is not specifically described in this Certificate as a covered service; or that is related to service or care not covered under this Certificate; even when a Participating Provider considers the service or care to be Medically Necessary and appropriate. For example, this Certificate does not cover services provided and billed by a Hospital or other Facility.
 21. **Nutritional Therapy.** We will not provide coverage for any service or care related to nutritional therapy, unless we determine that it is Medically Necessary or that it qualifies as diabetes self-management education. We will not provide coverage for commercial weight loss programs or other programs with dietary supplements.
 22. **Personal Comfort Services.** We will not provide coverage for the following service or care that is for personal comfort: radio, telephone, television, or beauty and barber services.
 23. **Prescription Drugs.** We will not provide coverage for service or care related to prescription drugs, over-the-counter (nonprescription) drugs, or injections, except for: prescription drugs, and/or injections that are administered to you in the course of a covered outpatient or inpatient treatment in a Professional Provider's office.
 24. **Private Duty Nursing Service.** We will not provide coverage for service or care provided by a private duty registered nurse or licensed practical nurse, even if ordered by your physician or licensed health care professional.

25. **Prohibited Referral.** We will not provide coverage for any pharmacy, clinical laboratory, radiation therapy, physical therapy, x-ray, or imaging services that were provided pursuant to a referral prohibited by the New York Public Health Law.
26. **Reproductive Procedures.** We will not provide coverage for the following reproductive procedures or services: in vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cloning, sperm banking and donor fees associated with artificial insemination or other procedures, or other procedures or categories of procedures excluded by statute.
27. **Routine Care Of The Feet.** We 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. We will, however, provide coverage for arch supports, foot inserts, other foot devices and orthopedic shoes under your benefits for orthotic devices.
28. **Self-Help Diagnosis, Training And Treatment.** We 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.
29. **Services Starting Before Coverage Begins.** If you are receiving care on the Effective Date of your coverage under this Certificate, we will not provide benefits for any service or care you receive:
 - A. Prior to the Effective Date of your coverage under this Certificate; or
 - B. On or after the Effective Date of your coverage under this Certificate, if that service or care is covered under any other health benefits contract, program, or plan.
30. **Smoking Cessation Programs.** We will not provide coverage for smoking cessation programs.
31. **Special Charges.** We will not provide coverage for charges billed to you for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, or completion of claims forms.
32. **Social Counseling And Therapy.** We will not provide coverage for any service or care related to family, marital, religious, sex, or other social counseling or therapy, except as otherwise provided under this Certificate.
33. **Transsexual Surgery And Related Services.** We will not provide coverage for surgery, or for any service or care set forth in this Certificate that is related or leads up to such surgery, that is designed to alter the physical characteristics of your biologically determined gender to those of another gender, unless Medically Necessary.
34. **Unlicensed Provider.** We will not provide coverage for any service or care that is provided or prescribed by an unlicensed provider; or that is outside the scope of licensure of the duly licensed provider rendering the service or care.
35. **Vision; Hearing; Vision And Hearing Examinations, Therapies And Supplies.** We will not provide coverage for any service or care related to:
 - A. Routine eye or hearing examinations for the purpose of prescribing, fitting, servicing, or changing eyeglasses, contact lenses or hearing aids; except for the initial prescription for contact lenses or lenses and frames after cataract surgery;
 - B. Eyeglasses, lenses, frames, contact lenses or hearing aids except for the initial prescription for contact lenses or lenses and frames after cataract surgery; and
 - C. Vision or hearing therapy, vision training, or orthoptics.
36. **Weight Loss Services.** We will not provide coverage for any service or care in connection with weight loss programs. We will also not provide benefits for any covered service or care set forth in this Certificate when rendered in connection with weight reduction or dietary control, including, but not limited to, laboratory services, and gastric stapling, gastric by-pass, gastric bubble or other surgery for treatment of obesity, unless Medically Necessary.

37. **Workers' Compensation.** We will not provide coverage for any service or care for which benefits are provided under a workers' compensation or similar law.

SECTION EIGHT — WAITING PERIODS

1. **Pre-existing Conditions.** We will not provide coverage for any services related to a Pre-existing Condition until you have been continuously covered under this Certificate for at least 12 consecutive months, subject to crediting for prior coverage under Paragraph 2 below. This provision will not apply if your group has more than 300 members.

A Pre-existing Condition is any physical or mental condition; disease; or ailment for which medical advice, diagnosis, care or treatment was actually recommended or received by a licensed health care provider within the six-month period preceding your Enrollment Date. The Enrollment Date is the first of the following:

- A. Your Effective Date under this Certificate; or
- B. The first day of the waiting period that your group requires you to meet before you are eligible for coverage.

2. **Credit Toward Waiting Periods.** The time you were covered under any other health insurance or HMO contract or policy or employer-provided health benefit arrangement providing creditable coverage as defined by the Health Insurance Portability and Accountability Act before you became covered under this Certificate will be counted toward the waiting period if there was not a break in coverage greater than sixty-three (63) days between the termination of the previous coverage and your Enrollment Date under this Certificate. In the case of previous coverage any HMO affiliation period before coverage becomes effective shall be considered as time covered for purposes of providing credit for previous coverage.

Creditable coverage includes: coverage provided through health insurance; self-insured group health benefit plans; Medicaid; Medicare; government-sponsored health benefit programs, such as CHAMPUS, Peace Corps, or Indian Health Service; Federal Employees Health Benefits Program; a State health benefits risk pool; or coverage under a public health plan.

You have the right to obtain a certificate from the employer, insurer, HMO or governmental health benefit plan that provided your prior creditable coverage. The certificate will enable you to demonstrate the prior creditable coverage that will be counted toward fulfillment of the Pre-existing Condition waiting period under this Certificate. Contact us if you need help obtaining a certificate for your prior creditable coverage.

3. **Exceptions.** Pre-existing Condition waiting periods will not be imposed with respect to: (a) pregnancy; (b) any condition afflicting a newborn who is covered under creditable coverage on the 30th day following birth, provided that there has not been a continuous lapse of more than 63 days between the end of the creditable coverage and the child's enrollment date for coverage under this Certificate; (c) any condition afflicting an adopted child under age 18 who is covered under creditable coverage on the 30th day following adoption or placement for adoption, provided that there has not been a continuous lapse of more than 63 days between the end of the creditable coverage and the child's enrollment date for coverage under this Certificate; or (d) genetic information, including gene products; inherited characteristics that may derive from the individual or family member, including information regarding carrier status and information derived from lab tests that identify mutations in specific genes or chromosomes; physical medical examinations; family histories; and direct analysis of genes or chromosomes. However, if, within the six-month period prior to your Enrollment Date, you have been diagnosed with and have received medical advice or treatment for the condition indicated by the genetic information, the Pre-existing Condition waiting period will apply.

SECTION NINE — COORDINATION OF BENEFITS

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

1. **When You Have Other Health Benefits.** It is not unusual to find yourself covered by two health insurance contracts, plans 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, we will coordinate benefit payments with any payment made under the other plan. One company will pay its full benefit as the primary plan. The other company will pay secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance plan:
 - A. Any group or blanket insurance contract, plan or policy, including HMO and other prepaid group coverage, except that blanket school accident coverage or such coverage offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;
 - B. Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;
 - C. Any Blue Cross, Blue Shield, or other service type group plan;
 - D. Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and
 - E. Medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional "fault" type contracts.
2. **Rules To Determine Payment.** In order to determine which plan is primary, certain rules have been established. The first of the rules listed below which applies shall determine which plan shall be primary:
 - A. If the other plan does not have a provision similar to this one, then it will be primary;
 - B. If you are covered under one plan as an employee, subscriber or member and you are only covered as a dependent under the other plan, the plan which covers you as an employee will be primary; or
 - C. Subject to the provisions regarding separated or unmarried parents below, if you are covered as a child under both plans, the plan of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the plan that covered the parent longer is primary. If the other plan does not have the rule described immediately above, but instead has a rule based on gender of a parent and, as a result, the plans do not agree on which shall be primary, then the father's plan will be primary.

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

- (1) If the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.
- (2) If no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:
 - (a) First, the plan of the parent with custody of the child;
 - (b) Then, the plan of the spouse of the parent with custody of the child;
 - (c) Finally, the plan of the parent not having custody of the child.
- D. If you are covered under one of the plans as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, and you are covered as a laid-off or retired employee or a laid-off or retired employee's dependent under the other plan, the plan covering you as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.

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

3. **Payment Of The Benefit When This Plan Is Secondary.** When this plan is secondary, the benefits of this plan will be reduced so that the total benefits payable under the other plan and this plan do not exceed your expenses for an item of service. However, we will not pay more than we would have paid if we were primary.

We count 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. We will request information from that plan so we can process your claims. If the primary plan does not respond within 30 days, we will assume its benefits are the same as ours. If the primary plan sends the information after 30 days, we will adjust our payment, if necessary.

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

4. **Right To Receive And Release Necessary Information.** We have the right to release or obtain information that we believe necessary to carry out the purpose of this section. We 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. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information that we request. If you do not furnish the information to us, we have the right to deny payments.
5. **Payments To Others.** We may repay to any other person, insurance company or organization the amount which it paid for your covered services and which we decide we should have paid. These payments are the same as benefits paid.
6. **Our Right To Recover Overpayment.** In some cases we may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other plan. You must sign any document that we deem necessary to help us recover any overpayment.

SECTION TEN — TERMINATION OF YOUR COVERAGE

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

1. **Termination Of The Group Contract.** This Certificate is provided under the terms of the Group Contract between us and the group contract holder. The Group Contract is effective for one year and will automatically be renewed each year unless it is terminated as set forth below.
- A. The group contract holder terminates the Group Contract pursuant to its terms. In this case, your coverage will terminate on the date the group contract holder terminates;
 - B. We do not receive premium payment from the group contract holder as of the date the premium was due. In this case, your coverage will end on the date to which the premium has been paid;
 - C. The group contract holder has committed fraud or made an intentional misrepresentation of material fact under the terms of the Group Contract. In this case, your coverage will terminate 30 days from the date we provide notice to you;
 - D. The group contract holder no longer qualifies as a group. We have certain administrative rules that describe our requirements for group contract holders. Our rules are consistent with New York State law and regulations governing health insurance. If you have a question about the rules that apply to your group contract holder, you may contact us and we will explain them to you.

When your group contract holder no longer meets our requirements, we will notify you. Your coverage will terminate 30 days from the date we provide notice to you;

- E. The group contract holder fails to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under section 4235 of the Insurance Law. In this case, your coverage will terminate 30 days from the date we provide notice to you;
 - F. The group contract holder no longer has any enrollee living, residing or working in New York State. In this case, your coverage will terminate 30 days from the date we provide notice to you;
 - G. Any reason approved by the New York State Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act. In this case, your coverage will terminate 30 days from the date we provide notice to you;
 - H. If we terminate the entire class of contracts to which this Certificate belongs. In this case, your coverage will terminate 90 days from the date we provide notice to you; or
 - I. If we withdraw from the applicable market through which you obtained coverage under this Certificate, and we cease offering any products in that market. In this case, your coverage will terminate six months from the date we provide notice to you.
2. **Termination Of Your Coverage Under This Certificate.** In the following instances, the Group Contract will continue in force, but your coverage under this Certificate will be terminated:
- A. You choose to terminate your coverage. You must give the group contract holder 30 days' written notice. Your coverage will terminate on the date to which your premium is paid;
 - B. You are no longer a member of the group. Your coverage will terminate on the date to which your premium is paid if you are no longer a member of the group;
 - C. You committed fraud in applying for coverage or in filing a claim under this Certificate. Your coverage will terminate 30 days from the date we provide notice to you;
 - D. Any reason approved by the Superintendent of Insurance. In this case, your coverage will terminate 30 days from the date we provide notice to you. A copy of the reason for the termination of your coverage will be provided to you upon request;
 - E. On your death or the death of the Subscriber. Your coverage under this Certificate will automatically terminate on the date after your death or the death of the Subscriber;
 - F. Termination of the Subscriber's marriage. If the Subscriber becomes divorced, or the Subscriber's marriage is annulled, coverage of the Subscriber's spouse under this Certificate will automatically terminate on the date of the divorce or annulment; or
 - G. Termination of coverage of a child. Coverage of a Subscriber's child under this Certificate will terminate on the date the child no longer qualifies as a dependent under Section Two of this Certificate or, if later, the next premium due date after we receive notice of termination.
3. **Continued Benefits After Termination For Total Disability.** When your coverage under this Certificate ends, benefits stop. However, if we determine you are totally disabled on the date the Group Contract terminates, or on the date your coverage under this Certificate terminates, and you have received services or care for the illness, condition, or injury that caused your total disability while you were covered under this Certificate, continued benefits may be available to you as follows:
- A. **When you may continue benefits.** When you are totally disabled, you may continue benefits for covered services to treat the total disability when your coverage under this Certificate ends because:
 - (1) You are no longer actively employed;
 - (2) You are no longer eligible for coverage under this Certificate; or
 - (3) The Group Contract terminates;

we will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within 31 days from the date your coverage ends. The Hospital stay and/or surgery must be for treatment of the injury, sickness, or pregnancy causing the total disability.

B. When continued benefits end. The continued benefits will terminate when:

- (1) You have used all the benefits available;
- (2) We determine that you are no longer totally disabled; or
- (3) You reach the lifetime maximum amount payable by us.

We will never pay more than we would have paid, had you remained covered under this Certificate.

4. 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. If you are not entitled to temporary continuation of coverage under COBRA, you may be entitled to temporary coverage under the New York Insurance Law as described below. Call or write your employer or us to find out if you are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

Under New York State law, if you lose coverage because of termination of employment or membership in the class or classes eligible for coverage, you may continue coverage for yourself and your eligible dependents subject to the following conditions:

- A. You are not entitled to Medicare; and you are not covered under or eligible for other group coverage that does not exclude or limit coverage for pre-existing conditions;
- B. You must request continued coverage within 60 days after the later of: the date of termination; or the date you are given notice of continuation by the group. If you wish continuation under Subparagraph D. (4) below, you must notify the group within 60 days after a determination that you were disabled under the Social Security Act at the time of termination of employment or membership or within the first sixty days of continuation coverage;
- C. You must pay the premium (not more frequently than monthly) when due. The first payment is due within 60 days after the later of the date coverage would otherwise terminate or the date you are given notice of continuation by the group. The premium cannot exceed 102% of the group's premium rate;
- D. Coverage will terminate at the earliest of the following:
 - (1) The date 18 months after your coverage would have terminated because of termination of employment or membership;
 - (2) The date to which premiums are paid if you fail to make a timely payment;
 - (3) If you are an eligible dependent, the date 36 months after coverage would have terminated due to: death of the employee or member; divorce or legal separation, the employee or member's eligibility for Medicare; failure to qualify under the definition of "children";
 - (4) The date 29 months after coverage would have otherwise terminated because of termination of employment or membership if the employee or member is determined to have been disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first sixty days of continuation coverage. However, if the employee or member is no longer disabled, coverage will terminate at the later of the date in Subparagraph D. (1) above; or the month that begins more than 31 days after determination that the employee or member is no longer disabled; or
 - (5) The date the group no longer provides coverage to any of its employees or members.

5. **Supplementary Suspension, Continuation And Conversion Rights.** If you, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, and you enter active duty but the group contract holder does not voluntarily maintain your coverage, your coverage shall be suspended unless you elect in writing to the group contract holder, within 60 days of being ordered to active duty, to continue coverage under this Certificate for yourself and eligible dependents. Continued coverage shall not be subject to evidence of insurability. You must pay the required group rate premium in advance to the group contract holder, but not more frequently than once a month.

Supplementary continuation coverage shall not be available to any person who is, or could be, covered by Medicare or any other group coverage. Coverage available through the Federal government for active duty members of the armed forces shall not be considered group coverage for the purposes of this paragraph.

In the event that you are reemployed or restored to participation in the group upon return to civilian status after the period of continuation coverage or suspension, you (and your covered dependents if other than individual coverage applies), shall be entitled to resume coverage under this Certificate. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty provided the applicable premium has been paid from that date. No exclusion or waiting period shall be imposed in connection with resumed coverage except regarding:

- A. A condition that arose during the period of active duty and that has been determined by the secretary of veterans affairs to be a condition incurred in the line of duty; or
- B. A waiting period imposed that had not been completed prior to the period of suspension. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed eleven months.

In the event that you are not reemployed or restored to participation in the group upon return to civilian status, you shall have the right within 31 days of the termination of active duty, or discharge from hospitalization incident to active duty which continues for a period of not more than one year, to submit a written request for continuation to the group, or a request for conversion directly to us, as described elsewhere in this Certificate. Such individual conversion policy shall be effective on the day after the end of the period of supplementary continuation. If other than individual coverage applies and you elect supplementary continuation or if coverage is suspended, the supplementary conversion right shall be available to your spouse if divorce or annulment of the marriage occurs during the period of active duty, and if you die while on active duty, to your spouse and children covered under this Certificate, and to each child individually upon attaining the limiting age of coverage under this Certificate.

The supplementary conversion and continuation rights described above do not apply to you if this Certificate qualifies as an employer group health plan subject to the federal temporary continuation of coverage provisions of COBRA described above. The provisions relating to suspension of coverage shall apply to you even if the conversion and continuation rights do not apply.

SECTION ELEVEN — RIGHT TO NEW CONTRACT AFTER TERMINATION

You have the right to convert to a new contract if your coverage under this Certificate terminates under the circumstances described below.

1. **Termination Of The Group Contract.** If the Group Contract between us and the group contract holder is terminated as set forth in Section Ten, paragraph 1, and the group contract holder has not replaced the coverage for the group with similar and continuous health care coverage, whether insured or self-insured, you are entitled to purchase a new contract as a direct payment member.
2. **If You Are No Longer Covered In A Group.** If your coverage under this Certificate terminates under Section Ten, subparagraph 2. B because you are no longer a member of a group, you are entitled to purchase a new contract as a direct payment member.
3. **On The Death Of The Subscriber.** If your coverage under this Certificate terminates under Section Ten, subparagraph 2. E because of the death of the Subscriber, you are entitled to purchase a new contract as a direct payment member.

4. **Termination Of Your Marriage.** If your coverage under this Certificate terminates under Section Ten, subparagraph 2. F because you become divorced from the Subscriber or your marriage is annulled, you are entitled to purchase a new contract as a direct payment member.
5. **Termination Of Coverage Of A Child.** If your coverage under this Certificate terminates under Section Ten, subparagraph 2. G because you no longer qualify as a child, you are entitled to purchase a new contract as a direct payment member.
6. **Termination Of Your Temporary Continuation Of Coverage.** If your coverage under this Certificate terminates under Section Ten, paragraph 4 because you are no longer eligible for continuation of coverage, you are entitled to purchase a new contract as a direct payment member.
7. **When To Apply For The New Contract.** If you are entitled to purchase a new contract, as described above, you must apply to us for the new contract within 45 days after termination of your coverage under this Certificate. You must also pay the first premium of the new contract within this same 45-day period.

However, notwithstanding the above, if we determine that you do not reside in New York State, you will not be entitled to purchase a new contract as a direct payment subscriber if:

 - A. We determine that similar coverage is available through the local Blue Cross and/or Blue Shield Plan operating in the area in which you are located; and
 - B. The time you were covered under this Certificate will count towards any applicable waiting periods under the available coverage.
8. **The New Contract.** The new contract will be our basic hospital and medical, standard HMO or HMO/POS contract issued upon conversion. However, if you are age 65 or over, the new contract will be one of the contracts issued to Medicare-eligible applicants; or the new contract will be our standard HMO or HMO/POS contract issued upon conversion.

SECTION TWELVE — GENERAL PROVISIONS

1. **No Assignment.** You cannot assign any benefits or monies due under the Group Contract or this Certificate 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 Certificate or your right to collect money from us for those services.
2. **Notice.** Any notice that we give to you under this Certificate will be mailed to your address as it appears on our records or to the address of the group contract holder. If you have to give us 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 Certificate, it may be necessary for us to obtain your medical records and information from Facilities or Professional Providers who treated you. Our 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 Certificate, you automatically give us permission to obtain and use those records for those purposes.

We agree to maintain that information in accordance with state and federal confidentiality requirements. However, you automatically give us permission to share that information with the New York State Department of Health, quality oversight organizations and third parties with which we contract to assist us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

4. **Who Receives Payment Under This Certificate.** Payments under this Certificate for service provided by a Participating Provider will be made directly by us to the provider. If you receive services from a Non-Participating Provider, we reserve the right to pay either you or the provider.
5. **Time To File Claims.** Claims for services under this Certificate must be submitted to us for payment within 12 months after you receive the services for which payment is being requested.

6. **Time To Sue.** No action at law or in equity may be maintained against us prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Certificate. You must start any lawsuit against us under this Certificate within twenty-four months from the date you received the service for which you want us to pay.
7. **Venue For Legal Action.** If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against us 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 we bring against you.
8. **Choice Of Law.** This Certificate shall be governed by the laws of the State of New York.
9. **Recovery Of Overpayments.** On occasion a payment will be made when you are not covered, for a service that is not covered, or which is more than is proper. When this happens we will explain the problem to you and you must return the amount of the overpayment to us within 60 days after receiving notification from us.
10. **Right To Offset.** If we make a claim payment to you or on your behalf in error or you owe us any money, you must repay the amount you owed to us. If we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we owe you.
11. **Continuation Of Benefit Limitations.** Some of the benefits under this Certificate are limited to a specific number of visits and lifetime maximums. 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 dependent to Subscriber, all benefits previously utilized when you were a dependent will be applied toward your new status as a Subscriber.
12. **Subrogation.** In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and we pay benefits as a result of that injury or illness, we will be subrogated and succeed to the right of recovery against the party responsible for your illness or injury to the extent of the benefits we have paid.

Duty to Cooperate with Us — Possible Penalties for Failure to Cooperate. Under certain circumstances, we are also entitled to be reimbursed for the benefits we have paid from a settlement or a judgment you receive from the party responsible for your illness or injury. This and other penalties which apply under certain circumstances are noted below. Those circumstances are:

- A. The settlement or judgment you receive from the party responsible for your illness or injury specifically identifies or allocates monetary sums directly attributable to expenses for which we have paid benefits; or
- B. You fail to cooperate with us in proceeding against the party responsible for your illness or injury to recover the benefits we have paid. We will pay all expenses associated with a legal action instituted on our initiative.

The penalty for failing to cooperate under Subparagraph B above is that you will be responsible to repay to us the amount of the benefits we have paid. We agree to invoke Subparagraph B only when your illness or injury caused by a third party results in our expenditure on your behalf of an amount exceeding \$500 under this coverage. In any of these provisions where we must give our prior written consent, we agree not to unreasonably withhold our prior consent and we agree to waive all penalties under these provisions if we do not give or withhold our prior consent within 30 days from the date you or your legal representative seeks prior consent in writing from us.

13. **Who May Change This Certificate.** The Certificate may not be modified; amended; or changed, except in writing, and signed by our Chief Operating Officer (COO) or a person designated by the COO. No employee; agent; or other person is authorized to interpret; amend; modify; or otherwise change the Certificate 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 or person designated by the COO.

14. **Changes In This Certificate.** We may unilaterally change this Certificate upon the group's renewal, if we give the group contract holder 44 days' prior notice.
15. **Renewal Date.** The renewal date for the Certificate is January 1 of each year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by us or the group contract holder as permitted by the Certificate or by you upon 30 days' prior written notice to the group contract holder.
16. **Agreements Between The Plan And Participating Providers.** Any agreement between us and Participating Providers may only be terminated by us or the providers. This Certificate does not require any provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.
17. **Material Accessibility.** We will give the group contract holder, and the group contract holder will give Members, identification cards, Certificates, Riders and other necessary materials.
18. **Refund.** We will give any refund of premiums, if due, to the group contract holder.
19. **Notice Of Claim.** Claims for services under this Certificate must include all information designated by us 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 will not be accepted and must be resubmitted with all necessary information.
20. **Identification Cards.** Identification cards are issued by us for identification only. Possession of any identification card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits the Member's premiums must be paid in full at the time that the services are sought to be received. Coverage under this Certificate may be terminated by us if the Member allows another person to wrongfully use the identification cards.
21. **Right To Develop Guidelines And Administrative Rules.** We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Certificate. 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 Certificate. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Certificate.
22. **Furnishing Information And Audit.** The group contract holder and all persons covered under this Certificate will promptly furnish us with all information and records that we may require from time to time to perform our obligations under this Certificate. You must provide us with information over the telephone for reasons like the following: to allow us to determine the level of care you need; so that we may certify care authorized by your physician; or to make decisions regarding the Medical Necessity of your care. The group contract holder will, upon reasonable notice, make available to us, and we may audit and make copies of, any and all records relating to group enrollment at the group contract holder's New York office.
23. **Enrollment; ERISA.** The group contract holder further 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 Certificate, and any other information required to confirm their eligibility for coverage. The group contract holder will provide us with the enrollment form including your name, address, age, and social security number and to advise us in writing when you are to be added to or subtracted from our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date the group's contract with us. If the group contract holder fails to so advise us, the group contract holder will be responsible for the cost of any claims paid by us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 30 days.

The group contract holder 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 contract holder, or a third party appointed by the group contract holder. We are not the ERISA plan administrator.

24. **Reports And Records.** We are entitled to receive from any provider of services to Members, information reasonably necessary to administer this Certificate subject to all applicable confidentiality requirements as defined in the General Provisions Section of this Certificate. By accepting coverage under this Certificate, the Member, for himself or herself, and for all covered dependents 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 us or a medical, dental, or mental health professional that we may engage to assist us 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 us, or a medical, dental, or mental health professional, that we may engage to assist us in reviewing a treatment or claim; and
 - C. Permit copying of the Member's records by us.
25. **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 the obligations created under this agreement.
26. **BlueCard — Calculation Of Member Liability.** Like all Blue Cross and Blue Shield Licensees (hereinafter "Plans"), we participate in a program called the BlueCard Program. This program provides benefits when you are outside our Service Area. When you receive health care services outside our Service Area from a provider that participates with a Blue Cross and Blue Shield Plan, your claims may be processed through the BlueCard Program.

Your liability for BlueCard covered services, if not covered by a flat dollar copayment, will be based on the lower of:

- A. The provider's billed charges; or
- B. The negotiated price that the out-of-area Blue Cross and Blue Shield Plan passes on to us. This negotiated price may be:
 - (1) The price the out-of-area Blue Cross and Blue Shield Plan paid its provider; or
 - (2) An estimated price that includes expected settlements, withholds, other payment arrangements, or non-claims transactions with the provider that the out-of-area Blue Cross and Blue Shield Plan factored in; or
 - (3) An average price that includes reductions to the bill that reflects the out-of-area Blue Cross and Blue Shield Plan's average expected savings.

The out-of-area Blue Cross and Blue Shield Plan may increase or decrease the negotiated price in the future to correct for over- or underestimation of past prices. But the amount paid by you will be your final price, and will not be affected by any future adjustment.

Some states may prohibit out-of-area Blue Cross and Blue Shield Plans from passing on to us their entire savings on a particular claim. Other states may require the out-of-area Blue Cross and Blue Shield Plan to add a surcharge to the bill. In either of these events, we would calculate your liability in accordance with the applicable law in effect at the time you received your services.

27. **Grievance Procedures.** We maintain procedures to resolve Member grievances. These procedures make sure that we resolve your questions, concerns, and complaints in a timely, fair manner.

A. **Filing a Grievance.** Our Grievance Procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by us. To initiate a grievance, just contact us. We keep all requests and discussions confidential and we'll take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry. We maintain a file on each grievance.

You can either contact our Customer Service Department by phone, in person or in writing to file a grievance. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

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

We will decide your grievance and notify you of our determination in writing within 30 calendar days of receipt of your grievance request.

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

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

B. **Notice of Determination.** The notice of determination of your grievance will include detailed reasons and, if a clinical matter is involved, the clinical rationale, and further appeal rights, if any. We will send notices to you or your representative and to your health care provider.

If you remain dissatisfied with our grievance determination or at any other time you are dissatisfied, you may:

Call the New York State Department of Insurance at 1-800-342-3736 or write them at:

New York State Department of Insurance
Consumer Services Bureau
One Commerce Plaza
Albany, NY 12257
www.ins.state.ny.us

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

We have developed Utilization Review policies to assist us in administering the Utilization Review program. These policies describe the process and procedures of Utilization Review activities. Reviews are conducted by registered nurses and our Medical Directors. All determinations that services are not Medically Necessary will be made by licensed physicians. We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not or were not Medically Necessary. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review at our office. For more information, you can contact us. Our failure to make a Utilization Review determination within the applicable time frames set forth below shall be deemed an adverse determination subject to an internal appeal.

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

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

With respect to urgent prospective claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 72 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

- B. **Concurrent Reviews.** When you are receiving services that are subject to concurrent review, a nurse will periodically assess the Medical Necessity and appropriateness of care you receive throughout the course of treatment. Once a case is assigned for concurrent review, a nurse will determine whether the services are Medically Necessary. If so, the nurse will authorize the care. If the nurse determines that Medical Necessity is lacking or that further evaluation is needed, the nurse will refer the case to a licensed physician.

Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to your provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision, but no later than 15 calendar days of receipt of the request.

For concurrent reviews that involve urgent matters, we will make a determination and provide notice to you and your provider within 24 hours of receipt of the request.

If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.

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

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

- D. **Notice of Adverse Determination.** A notice of adverse determination (notice that a service is not Medically Necessary) will include the reasons, including clinical rationale, for our determination. The notice will also advise you of your right to appeal our determination, give instructions for requesting an external appeal and for initiating an external appeal and specify that you may request a copy of the

clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal. We will send notices of determination to you or your designee and to your health care provider.

If, prior to making an adverse determination, no attempt was made to consult with the provider who recommended the service at issue, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For prospective and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to the provider, by telephone and in writing.

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

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

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

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review, or any other urgent matter, will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request.

If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal. Our failure to render a determination of your internal appeal within 60 calendar days shall be deemed a reversal of the initial adverse determination.

- F. **Notice of Determination of Internal Appeal.** The notice of determination of your internal appeal will indicate that it is a "final adverse determination" and will include the clinical rationale for our decision. It will also explain your rights to an external appeal, together with a description of the external appeal process and the time frames for initiating an external appeal. We will send notices of determination to you or your designee and to your health care provider.

29. External Appeal.

- A. **External Appeal in General.** You have the right to an "external appeal" of certain coverage determinations made by us. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by the State, and may not have a prohibited affiliation with any health insurer, health maintenance

organization (HMO), medical facility, or health care provider associated with the appeal. "Requested service" or "requested services" refers to the service or services for which you are requesting coverage.

You may have the right to an expedited external appeal if your attending physician attests that a delay in providing the requested service would pose an imminent or serious threat to your health. The timeframes for expedited external appeals are shorter than the timeframes for standard external appeals.

You may request an external appeal only if the requested service is a covered service under this Certificate.

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

In general, you may not request an external appeal unless we have issued a "final adverse determination" of your request for coverage through the first level of the internal appeal process. You may ask us to agree to an external appeal even though you have not obtained a final adverse determination through the first level of the internal appeal process; however, we have no obligation to agree to your request. If we do agree, we will send you a letter stating that we have agreed to an external appeal even though you have not obtained a final adverse determination.

To be eligible for external appeal, the final adverse determination issued through the first level of the internal appeal process must be based on a determination that the requested service is not Medically Necessary, or that the requested service is experimental or investigational. You do not have the right to an external appeal of any other determinations, even if those other determinations affect your coverage.

C. Conditions for External Appeals of Determinations of Medical Necessity. You may request an external appeal of a final adverse determination of Medical Necessity issued through the first level of the internal appeal process if you meet the conditions of this subparagraph and the general requirements of Subparagraph B above. The provisions of this subparagraph apply only to external appeal of Medical Necessity determinations.

To request external appeal under this subparagraph, the final adverse determination must indicate that the requested service is not Medically Necessary. Subparagraph G below provides information on requesting an external appeal.

D. Conditions for External Appeals of Determinations Involving Experimental or Investigational Treatment. This subparagraph governs external appeals of determinations involving experimental or investigational treatment. This subparagraph does not govern determinations involving services provided in clinical trials that are governed by Subparagraph E below.

In order to request an external appeal under this subparagraph, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one that, according to the current diagnosis of your attending physician, has a high probability of causing your death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

In addition, your attending physician must certify: that standard health services or procedures have been ineffective, or would be medically inappropriate in treating your life-threatening condition or disease; or, that no more beneficial standard treatment exists which is a covered service under this Certificate.

Your attending physician must have recommended a health service or procedure (including off-label usage of a pharmaceutical product) which, based on at least two documents from the available medical literature, is likely to be more beneficial to you than any standard covered health service or procedure. To make this recommendation, your attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

If you meet the requirements of this subparagraph and all of the requirements of Subparagraph B, you may request an external appeal. Subparagraph G provides information on requesting an external appeal.

E. External Appeals of Determinations Involving Clinical Trials. This subparagraph governs external appeals of determinations involving services provided in clinical trials.

In order to request an external appeal under this subparagraph, your attending physician must certify that you have a life-threatening or disabling condition or disease as described in Subparagraph D above. In addition, your attending physician must certify that a clinical trial for your condition exists and that you are eligible to participate in the clinical trial.

Your attending physician must also recommend that you participate in the clinical trial. To make this recommendation, your attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The clinical trial for which you are requesting coverage must be peer-reviewed, reviewed and approved by a qualified Institutional Review Board, and approved by one of the following:

- (1) The National Institutes of Health (NIH), an NIH cooperative group or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs;
- (2) An entity that has been identified by the NIH as a qualified non-governmental research entity; or
- (3) An Institutional Review Board of a facility that has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

If you meet the requirements of this subparagraph and all of the requirements of Subparagraph B, you may request an external appeal. Subparagraph G below provides information on requesting an external appeal.

F. Effect of the External Appeal Agent's Decision; Coverage. The decision of the External Appeal Agent is binding on both parties. If the External Appeal Agent decides in our favor, we will not cover the requested service. If the external appeal agent decides in your favor, we will cover the service as follows:

- (1) For services denied as not Medically Necessary, we will treat the service as Medically Necessary and provide coverage subject to all other conditions of this Certificate.
- (2) For services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of this Certificate.
- (3) For services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of this Certificate. We are not required to pay for drugs or devices that are the subject of the clinical trial.

We will not provide coverage for any service that is not a covered service under this Certificate. In addition, this subparagraph does not alter any cost-sharing responsibilities as otherwise provided for in this Certificate.

- G. **Requesting an External Appeal.** If you meet the conditions described above, you may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your physician may file an appeal on your behalf. We will send a standard request form to you when we have made a final adverse determination at the first level of the internal appeal process. You or your physician may obtain additional standard request forms at any time from the State Insurance Department, the Department of Health, or by contacting us.

You must file your request for an external appeal with the State Insurance Department within 45 days of receiving a final adverse determination as a result of the first level appeal process, or within 45 days of receiving a letter from us waiving the internal review process. We do not have the authority to grant extensions of this deadline.

Additional internal appeals may be available to you which are optional. However, regardless of whether you participate in additional internal appeals, your application for external appeal must be filed with the New York State Department of Insurance within 45 days from your receipt of the notice of final adverse determination from a first level internal appeal in order to be eligible for review by an external appeal agent.

You may be charged a fee of up to \$50 to request an external appeal, which may be waived if we determine that paying the fee is a financial hardship. The fee is returned if your external appeal is successful.

If you do not understand any part of the external appeal process or if you have questions regarding your right to external appeal, you may contact us, the State Insurance Department, or the Department of Health.



ENHANCED BENEFITS RIDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds certain benefits to your Basic Hospital and Basic Medical Certificates of Coverage. All of the terms, conditions and limitations of the Certificates to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Cost Sharing Expenses.**

- A. **Deductible.** Except where stated otherwise, you must pay the first \$250 of Allowable Expenses incurred for services of Participating and Non-Participating Providers under this Rider during each Calendar Year. If you have other than individual coverage, the Deductible applies to each person covered under this Rider. However, if more than two people are covered under this Rider, after Deductible payments for any and all persons covered under this Rider total \$750 in a Calendar Year, no further Deductible will be required for any person covered under this Rider for that Calendar Year.

Covered expenses incurred under this Rider and counted toward the Deductible during the calendar months of October, November and December shall also be applied toward the Deductible for the next succeeding Calendar Year.

- B. **Coinsurance.** Except where stated otherwise, after you have satisfied the annual Deductible described above, you will be responsible for a percentage of the Allowable Expense. The Coinsurance amount you must pay is 20%.
- C. **Additional Payments For Services Of Non-Participating Providers.** When you receive covered services from a Non-Participating Provider, in addition to the Coinsurance and the annual Deductible described above, you must also pay the amount, if any, by which the provider's actual charge exceeds the Allowable Expense. This means that the total of our coverage and your Deductible and Coinsurance may be less than the provider's actual charge.
- D. **Maximum Coinsurance Amounts.** When you have expended \$500 for Coinsurance in a Calendar Year, we will provide coverage for 100% of the Allowable Expense for services covered under this Rider for the remainder of that Calendar Year.

If other than individual or two-person coverage applies, when members of the same family covered under this Rider have paid an aggregate of \$1,500 in a Calendar Year in payment of Coinsurance, we will provide coverage for 100% of the Allowable Expense for the balance of that Calendar Year. You will remain responsible for any charges of a Non-Participating Provider that are in excess of the Allowable Expense.

2. **Additional Days and Visits Covered after Benefits under your Certificates are Exhausted.**
 - A. **Inpatient Care.** We will provide coverage for additional days of inpatient Hospital care, mental health care, substance use disorder and physical rehabilitation after you have exhausted the benefits available under your Basic Hospital Certificate. The Deductible and Coinsurance described in Paragraph 1 above do not apply to additional days of inpatient care covered under this subparagraph.
 - B. **Home Care.** We will provide coverage for up to 325 additional home care visits in a Calendar Year after you have exhausted the benefits available under your Basic Hospital Certificate.
 - C. **Outpatient Mental Health Care and Chemical Dependency.** We will provide coverage for additional visits for diagnosis and treatment of Mental Illnesses and chemical dependence after you have exhausted the benefits available under your Basic Hospital and Basic Medical Certificates.
 - D. **Inpatient Medical Services.** We will provide coverage for additional visits by Professional and other covered medical Providers on any day of inpatient care covered under Subparagraph A above.
3. **Professional Services.** We will provide coverage for the services of Professional Providers described below.
 - A. **Vision Examinations.** We will provide coverage for diagnostic vision examinations to determine disease or injury to the ear.
 - B. **Hearing Examinations.** We will provide coverage for diagnostic hearing examinations to determine disease or injury to the ear.
 - C. **Diagnostic Office Visits.** We will provide coverage for diagnostic office visits to diagnose and treat injury or illness.
 - D. **Office Consultations.** We will provide coverage for consultations billed by a physician. A consultation is professional advice given by a physician to your attending physician upon the request of your attending physician.
 - E. **Allergy Testing And Treatment.** We will provide coverage for allergy testing and treatment, including test and treatment materials. Allergy testing includes, but is not limited to, scratch and prick tests to determine the nature of allergies. Allergy treatment includes desensitization treatments (injections) to alleviate allergies, including allergens.
 - F. **Chiropractic Care.** We will provide coverage for services rendered in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. However, such services must be:
 - (1) Rendered by a provider licensed to provide such services; and
 - (2) Determined by us to be Medically Necessary.

4. **Treatment Of Diabetes.** We will provide coverage for the following equipment and supplies for the treatment of diabetes which we determine to be Medically Necessary and when prescribed or recommended by your Professional Provider or other Participating 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;
 - 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 the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

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

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

We 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 us. 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. We will also pay for home visits, when Medically Necessary.

Education is also covered when provided by the following Participating 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.

5. **Benefits.**

Participating Providers. Except as otherwise provided below, services of Participating Providers are covered at 80% of the Allowable Expense, after Deductible.

Benefits for diabetic supplies and insulin, diabetic education and diabetic durable medical equipment are covered at 100% of the Allowable Expense.

Benefits for additional days of inpatient care covered under Subparagraph 2. A above are covered at 100% of the Allowable Expense.

Non-Participating Providers. Except as otherwise provided below, services of Non-Participating Providers are covered at 80% of the Allowable Expense, after Deductible.

Benefits for diabetic supplies and insulin, diabetic education and diabetic durable medical equipment are covered at 80% of the Allowable Expense.

Benefits for additional days of inpatient care covered under Subparagraph 2. A above are covered at 100% of the Allowable Expense.

6. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.**

The new contract to which you may be entitled if your coverage under your Certificates ends may not include any of the benefits of this Rider.

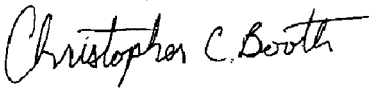
EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield

165 Court Street

Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



RIDER TO WAIVE WAITING PERIOD

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds certain benefits for Pre-existing Conditions to your Certificate of Coverage. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Waiting Period Waived.** We will waive any waiting period for Pre-existing Conditions that applies to services otherwise covered under your Certificate. You will not have to satisfy a waiting period before you have coverage for Pre-existing Conditions.
2. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Certificate ends may not include any of the benefits of this Rider.

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By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR SKILLED NURSING FACILITY CARE

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds certain benefits for Skilled Nursing Facility care to your Basic Hospital and Basic Medical Certificates of Coverage.

- Skilled Nursing Facility Care.** We will provide coverage for care in a Skilled Nursing Facility if we determine that hospitalization would otherwise be Medically Necessary for the care of your condition, illness or injury. We will cover care in semi-private accommodations and all Medically Necessary services provided by the Skilled Nursing Facility.

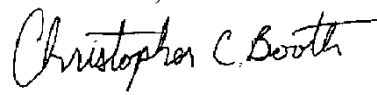
We will also provide coverage for medical visits by a Professional Provider on any day of Skilled Nursing Facility care covered above. We will not provide coverage for medical visits by Facility employees or interns, even if they are Professional Providers. The Professional Provider's services must be documented in the Facility records. We will only cover one visit per day per Professional Provider.
- Number Of Days Of Care.** We will pay for up to 120 days of Skilled Nursing Facility care in a Calendar Year combined with physical rehabilitation. A Single Confinement means one or more Skilled Nursing Facility admissions due to the same or related causes. When you are admitted after at least 90 days of non-confinement, you will begin a new Single Confinement.

Services of Participating and Non-Participating Providers will both be counted toward your annual limit.
- Custodial Care Excluded.** We will not pay for custodial care, which 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.
- Benefits.** Facility services are covered at 100% of the Allowable Expense.
- New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Certificates ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



ENDORSEMENT FOR SKILLED NURSING FACILITY CARE

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Endorsement adds certain benefits for Skilled Nursing Facility care to your Enhanced Benefits Rider. All of the terms, conditions and limitations of the Rider to which this Endorsement is attached also apply to this Endorsement, except where they are specifically changed by this Rider.

1. **Skilled Nursing Facility Care.** We will provide coverage for care in a Skilled Nursing Facility on any day we determine that hospitalization would otherwise be Medically Necessary for the care of your condition, illness or injury. We will cover care in semi-private accommodations and all Medically Necessary services provided by the Skilled Nursing Facility.

We will also provide coverage for medical visits by a Professional Provider on any day of Skilled Nursing Facility care covered above. We will not provide coverage for medical visits by Facility employees or interns, even if they are Professional Providers. The Professional Providers services must be documented in the Facility records. We will only cover one visit per day per Professional Provider.

We will only provide coverage under this Endorsement after you have exhausted the benefits under the Rider for Skilled Nursing Facility Care that attaches to your Basic Hospital and Basic Medical Certificates of Coverage.

2. **Custodial Care Excluded.** We will not pay for custodial care, which 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.
3. **Benefits.** Services are covered at 100% of the Allowable Expense. The maximum Coinsurance amount set forth in your Enhanced Benefits Rider also applies to Coinsurance under this Endorsement.
4. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Endorsement.** The new contract to which you may be entitled if your coverage under your Rider ends may not include any of the benefits of this Endorsement.

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President and Chief Executive Officer



ENDORSEMENT FOR OUTPATIENT THERAPY SERVICES

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Endorsement adds certain benefits for outpatient therapy visits to your Enhanced Benefits Rider. All of the terms, conditions and limitations of the Rider to which this Endorsement is attached also apply to this Endorsement, except where they are specifically changed by this Endorsement.

1. **Covered Therapies.** We 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, or by another Facility employee or Professional Provider who is licensed to provide such services, and when we determine that your condition is subject to significant clinical improvement through relatively short-term therapy.

We will cover services provided in a Professional Provider's office and in the outpatient department of a Facility.

2. **Benefits.** Services are covered at 100% of the Allowable Expense.
3. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Endorsement.** The new contract to which you may be entitled if your coverage under your Rider ends may not include any of the benefits of this Endorsement.

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President and Chief Executive Officer



ENDORSEMENT FOR DURABLE MEDICAL EQUIPMENT; EXTERNAL PROSTHETIC DEVICES AND ORTHOTIC DEVICES; MEDICAL SUPPLIES

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Endorsement adds certain benefits for the following to your Enhanced Benefits Rider: durable medical equipment; external prosthetic devices and orthotic devices; medical supplies. All of the terms, conditions and limitations of the Rider to which this Endorsement is attached also apply to this Endorsement, except where they are specifically changed by this Endorsement.

1. **Durable Medical Equipment.** We will provide coverage for the rental, purchase, repair, or maintenance of durable medical equipment and for supplies and accessories necessary for the proper functioning of the equipment. We will provide coverage for durable medical equipment that your physician or other licensed/authorized provider and our 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. We will determine whether the item should be purchased or rented.

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

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

2. **External Prosthetic Devices.** We will provide coverage for external prosthetic devices necessary to relieve or correct a condition caused by an injury or illness. We will cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Your physician must order the prosthetic device for your condition before its purchase. Although we require that a physician prescribe the device, this does not mean that we will automatically determine you need it. We will determine if the prosthetic device is Medically Necessary. We will only provide benefits for a prosthetic device that we determine can adequately meet the needs of your condition at the least cost.

A prosthetic device is an artificial organ or body part, including, but not limited to, artificial limbs and eyes. External prosthetic devices include, for example, the following that are used to replace functioning natural body parts: artificial arms, legs, and eyes; ostomy bags and supplies required for their use; and catheters. Prosthetic devices do not include, for example: hearing aids; eyeglasses; contact lenses; medical supplies; wigs; or foot orthotics such as arch supports or insoles, regardless of the Medical Necessity of those items. Dentures or other devices used in connection with the teeth are also not covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Not included in this benefit are: the cost of rental, purchase, repair, or maintenance of prosthetic devices because of misuse, loss, natural disaster, or theft unless approved in advance by the Medical Director. No coverage is provided for the additional cost of a deluxe device that is not Medically Necessary. We will not provide coverage for delivery or service charges, or for routine maintenance related to prosthetic devices.


3. **Orthotic Devices.** We will provide coverage for orthotic devices that are rigid or semi-rigid (having molded plastic or metal stays) when the devices are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness. We will cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Orthotic devices include orthopedic braces and custom-built supports. Your physician must order the orthotic device for your condition before its purchase. Although we require that a physician prescribe the device, this does not mean that we will automatically determine you need it. We alone will determine if the orthotic device is Medically Necessary. We will only provide benefits for an orthotic device that we determine can adequately meet the needs of your condition at the least cost.
4. **Medical Supplies.** We will provide coverage for disposable medical supplies when you are not an inpatient in a Facility and we determine that a large quantity is necessary for the treatment of conditions such as cancer, diabetic ulcers, surgical wounds and burns. Disposable medical supplies: are used to treat conditions caused by injury or illness; do not withstand repeated use (cannot be used by more than one patient); and are discarded when their usefulness is exhausted. Examples of disposable medical supplies include: bandages; surgical gloves; tracheotomy supplies; and compression stockings. Your physician must order these supplies.

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

5. **Benefits.** Services are covered at 100% of the Allowable Expense. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary. The maximum Coinsurance amount set forth in your Enhanced Benefits Rider also applies to Coinsurance under this Endorsement.
6. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Endorsement.** The new contract to which you may be entitled if your coverage under your Rider ends may not include any of the benefits of this Endorsement.

EXCELLUS HEALTH PLAN, INC.
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By: 

Christopher C. Booth
President and Chief Executive Officer



ENDORSEMENT FOR ACUPUNCTURE

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Endorsement adds certain benefits for acupuncture to your Enhanced Benefits Rider. All of the terms, conditions and limitations of the Rider to which this Endorsement is attached also apply to this Endorsement, except where they are specifically changed by this Endorsement.

1. **Acupuncture.** We will provide coverage for acupuncture services. Services must be rendered by a Professional Provider licensed to provide such services; and determined by our Medical Directors to be Medically Necessary.
2. **Benefits.** Services are covered at 100% of the Allowable Expense. The maximum Coinsurance amount set forth in your Enhanced Benefits Rider also applies to Coinsurance under this Endorsement.
3. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Endorsement.** The new contract to which you may be entitled if your coverage under your Rider ends may not include any of the benefits of this Endorsement.

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165 Court Street
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By: 

Christopher C. Booth
President and Chief Executive Officer



ENDORSEMENT FOR PRIVATE DUTY NURSING SERVICES

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Endorsement adds certain benefits for private duty nursing services to your Enhanced Benefits Rider. All of the terms, conditions and limitations of the Rider to which this Endorsement is attached also apply to this Endorsement, except where they are specifically changed by this Endorsement.

1. **Private Duty Nursing.** We will provide coverage for Medically Necessary private duty nursing as an inpatient or in your home subject to the following conditions:
 - A. Inpatient services must be performed by a Licensed Practical Nurse (LPN) or Registered Nurse (RN).
 - B. Services in your home must be performed by an RN, ordered by your physician and you must not be receiving home care.
 - C. The nurse must not be a relative or a person living in your home.
 - D. The services performed must be consistent with the diagnosis, disease or condition for which you are being treated. We will not pay for custodial care.
2. **Benefits.** Services are covered at 80% of the Allowable Expense, after Deductible. The maximum Coinsurance amount set forth in your Enhanced Benefits Rider also applies to Coinsurance under this Endorsement.
3. **New Contract After Termination of Coverage May Not Contain the Benefits of This Endorsement.** The new contract to which you may be entitled if your coverage under your Rider ends may not include any of the benefits of this Endorsement.

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President and Chief Executive Officer



ALLOWABLE EXPENSE AND INPATIENT CARE; SUBSTANCE USE DISORDER BENEFITS RIDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes certain benefits under your Certificate of Coverage. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Allowable Expense.** Under this Rider, the Allowable Expense definition in the Introduction and Definitions Section of your Certificate is hereby deleted in its entirety and replaced with the following:
 - A. **Allowable Expense.** "Allowable Expense" means the maximum amount we will pay to a provider for the services or supplies covered under this Certificate, before any applicable cost-sharing amounts are subtracted, except as otherwise provided below. We determine our Allowable Expense as follows:
 - (1) The Allowable Expense for covered services received from a Facility is the amount set by state or federal law. In the absence of state or federal law, the Allowable Expense for Participating Providers will be the amount we have negotiated with the Facility or the amount approved by another Blue Cross and Blue Shield Plan. However, when the Facility's charge is less than the amount we have negotiated with the Facility, your cost-sharing amounts will be based on the Facility's charge.

The Allowable Expense for Non-Participating Providers will be 80% of the provider's charge.

- (2) We assign a fee schedule amount to services or procedures performed by a Professional Provider or a Provider of Additional Health Services based upon our review of factors such as Medicare rates, provider specialty, geographic location and network adequacy. In the absence of a set fee schedule amount, we will determine the Allowable Expense amount taking into consideration the type of covered service, provider specialty and the average fee schedule amount for similar covered services. The Allowable Expense for covered services performed by a Participating Professional Provider will be the lowest of: the amount listed on our fee schedule; the amount approved by another Blue Cross and Blue Shield Plan; the Professional Provider's or Provider of Additional Health Service's charge.

The Allowable Expense for services of Non-Participating Providers inside our Service Area is: (a) the lower of 100% of the national Medicare fee schedule amount for the date(s) on which the services were rendered or the provider's charge; and (b) for services for which there is no Medicare fee schedule amount, 75% of the provider's charge. The Allowable Expense for services of Non-Participating Providers outside our Service Area is: (a) the lower of 150% of the national Medicare fee schedule amount for the date(s) on which the services were rendered or the provider's charge; and (b) for services for which there is no Medicare fee schedule amount, 75% of the provider's charge, or, if lower, the amount approved by another Blue Cross and Blue Shield Plan.

- (3) The Allowable Expense for services rendered by a Non-Participating Provider in connection with an Emergency Condition is the provider's charge.

2. **Conditions for Inpatient Care; Limitations on Number of Days of Care.** Under this Rider, Inpatient Facility care is subject to the following conditions and limitations:
- A. **Inpatient Hospital Care.** We will provide coverage when you are required to stay in a Hospital for acute medical or surgical care and are not admitted to the hospital for mental health care or for diagnosis and treatment of chemical dependence and/or abuse.
 - B. **Mental Health Care.** We will provide coverage for diagnosis and "active treatment" of Mental Illnesses in a Facility that is a hospital as defined by subdivision ten of section 1.03 of the New York Mental Hygiene Law. A hospital does not include a: residential treatment program; group home; school; camp; halfway house; or other supportive housing. The term "active treatment" means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meets standards prescribed pursuant to the regulations of the Commissioner of Mental Health.

We will also provide coverage for care in a licensed partial hospitalization program. A partial hospitalization program is an ambulatory treatment program that provides a medically supervised alternative to inpatient treatment.
 - C. **Substance Use Disorder.** We will provide coverage for inpatient Facility care for substance use disorder as described below.
 - (1) **Inpatient Detoxification.** We will provide coverage for active treatment for detoxification needed because of chemical dependence. This coverage is available only for services rendered in and billed by:
 - (a) A Facility in New York State which is certified by the Office of Alcoholism and Substance Abuse Services;
 - (b) A program we recognize as a chemical dependence and abuse treatment program; or
 - (c) A Facility in another state that we recognize is approved by JCAHO as an alcoholism or chemical dependence and abuse treatment program and meets the appropriate state licensing. If a government hospital meets these criteria, services rendered there will be covered unless no charge would have been made in the absence of coverage under your Certificate.
 - (2) **Inpatient Chemical Dependence and Abuse Rehabilitation.** We will provide coverage for the diagnosis and active treatment for rehabilitation of chemical dependence and abuse. Inpatient rehabilitation services are designed to initiate the treatment and recovery process when you are unable to participate in or comply with treatment outside a 24-hour structured treatment setting. Nursing services are available 24 hours per day. Inpatient treatment includes management of any of your physical or mental complications or co-morbidities. We will provide coverage for these medically-supervised services in a Facility that is a Plan approved provider for the active rehabilitation and treatment of chemical dependency. We will not provide benefits for intensive residential, community residential or supportive living services.
 - D. **Limitations on Number of Days of Care.** We will provide coverage for inpatient care as described in Subparagraphs A, B and C above on any day on which it is Medically Necessary for you to receive inpatient care.

Inpatient Care for Substance Use Disorder. The following new subparagraph is hereby added to the paragraph entitled "Inpatient Services" in the Professional Services Section of your Certificate:

- C. **Substance Use Disorder.** We will provide coverage for visits by a Professional Provider on any day of inpatient Facility care for substance use disorder covered under your Basic Hospital Certificate of Coverage. We will not provide coverage for medical visits by Facility employees or interns, even if they are Professional Providers. The Professional Provider's services must be documented in the Facility records. We will only cover one visit per day per Professional Provider.

3. **New Contract After Termination of Coverage May Not Contain the Benefits of This Rider.** The new contract to which you may be entitled if your coverage under your Certificate ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
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By: 

Christopher C. Booth
President and Chief Executive Officer



RIDER TO REMOVE PRIOR APPROVAL REQUIREMENT

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes certain utilization review requirements under your Certificate of Coverage and any Riders and Endorsements thereto (hereinafter collectively referred to as your "Certificate"). All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Prior Approval Not Required.** Your Certificate requires that you obtain our prior approval before you receive the following services: organ and bone marrow transplants; inpatient care for substance use disorder; inpatient detoxification; inpatient chemical dependence and abuse rehabilitation; in vitro fertilization and assisted reproductive technology. Under this Rider, the prior approval requirement is hereby deleted and you no longer need to obtain our approval prior to receiving those services.
2. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Certificate ends may not include any of the benefits of this Rider.

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ORAL SURGERY RIDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds certain benefits for oral surgery to your Certificate of Coverage, including any affected Riders thereto. All of the terms, conditions, and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Oral Surgery.** Under this Rider, we will provide coverage for oral surgery, including, but not limited to: surgical extractions, including removal of impacted teeth; tooth re-implantation; tooth transplantation; dental implant placement; apicoectomy; surgical treatment of odontogenic cysts and other lesions; alveoplasty; osseous surgery; gingival curettage; gingivectomy; and gingivoplasty.

Our Allowable Expense for the surgery includes coverage for: local anesthesia; routine pre- and post-operative procedures; and sutures and suture removal. Benefits for extraction of impacted wisdom teeth include coverage for IV sedation.

2. **Benefits.** Benefits for oral surgery are subject to the same cost sharing (Deductible, Copayment, Coinsurance) that applies to surgical procedures performed by a surgeon or other physician.

If you are covered under a dental plan that also provides benefits for oral surgery, the Coordination of Benefits Section of your Certificate will apply to determine whether we will reduce our payments under this Rider.

3. **New Contract After Termination of Coverage May Not Contain the Benefits of This Rider.** The new contract to which you may be entitled if your coverage under your Certificate ends may not include any of the benefits of this Rider.

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CLASSIC BLUE 2012 RIDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes certain benefit requirements under your Basic Hospital Certificate of Coverage and any affected Riders thereto. All of the terms, conditions, and limitations of the Certificate and Rider to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Program Limitation Does Not Apply to Pulmonary Rehabilitation and Cardiac Rehabilitation.** The limitations in the Outpatient Care Section of your Basic Hospital Certificate stating that we will only provide coverage for one program per lifetime for such rehabilitation services are hereby deleted. We will provide coverage for Medically Necessary outpatient care for pulmonary rehabilitation and cardiac rehabilitation.
2. **New Contract After Termination of Coverage May Not Contain the Benefits of This Rider.** The new contract to which you may be entitled if your coverage under your Certificate and Rider ends may not include any of the benefits of this Rider.

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ENDORSEMENT FOR ORAL SURGERY

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Endorsement adds certain benefits for oral surgery to your Enhanced Benefits Rider, including any affected Endorsements thereto. All of the terms, conditions, and limitations of the Rider to which this Endorsement is attached also apply to this Endorsement, except where they are specifically changed by this Endorsement.

1. **Oral Surgery.** Under this Rider, we will provide coverage for oral surgery, including, but not limited to: surgical extractions, including removal of impacted teeth; tooth re-implantation; tooth transplantation; apicoectomy; intraoral drainage of acute alveolar abscess; alveolectomy; gingivectomy; root canal therapy; and; gingivoplasty.

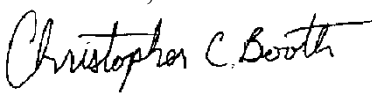
Our Allowable Expense for the surgery includes coverage for: local anesthesia; routine pre- and post-operative procedures; and sutures and suture removal. Benefits for extraction of impacted wisdom teeth include coverage for IV sedation.

2. **Benefits.** Services are covered at 80% of the Allowed Amount, subject to Deductible. The maximum Coinsurance amount set forth in your Enhanced Benefits Rider also applies to Coinsurance under this Endorsement. If you are covered under a dental plan that also provides benefits for oral surgery, the Coordination of Benefits Section of your Certificate will apply to determine whether we will reduce our payments under this Rider.
3. **New Contract After Termination of Coverage May Not Contain the Benefits of This Rider.** The new contract to which you may be entitled if your coverage under your Certificate ends may not include any of the benefits of this Rider.

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RIDER FOR CODING ACCURACY AND MULTIPLE SURGICAL PROCEDURES

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes certain benefits under your Contract, Certificate or Group Health Plan. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

- Coding Accuracy.** When you receive covered services from a Provider that does not have an agreement with us (known as a Non-Member, Non-Participating or Out-of-Network Provider), we 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 we pay 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. We will make one inclusive payment in that case, rather than a separate payment for each billed code. Another example of when we 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 we receive a claim that does not have the correct modifier, we will change it and make the appropriate payment.

When you receive services from a Non-Member, Non-Participating or Out-of-Network Provider, you must always pay the difference between the payment we allow under your Contract, Certificate or Group Health Plan, often referred to as the "Allowable Expense" or "Allowed Amount" and the provider's charge.

- Multiple Surgical Procedure Rules.** This paragraph applies when your Contract, Certificate or Group Health Plan covers surgical procedures performed and billed by a physician or other professional provider. If multiple surgical procedures are performed during the same operative session, the following rules apply. In these rules, the term "primary procedure" means the most expensive procedure, i.e., the procedure with the highest amount payable under your Contract, Certificate or Group Health Plan. The term "secondary procedure" means any procedure other than the primary procedure.

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

- A. Through the Same Incision.** If covered multiple surgical procedures are through the same incision, we will provide the benefits described in your Contract, Certificate or Group Health Plan for the primary procedure. We will pay 50% of the amount we would otherwise pay under your Contract, Certificate or Group Health Plan for secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions.

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

- B. **Through Different Incisions.** If covered multiple surgical procedures are performed during the same operative session but through different incisions, we will provide the following benefits:
- (1) The amount we would otherwise pay under your Contract, Certificate or Group Health Plan for the primary procedure; plus
 - (2) 50% of the amount we would otherwise pay under your Contract, Certificate or Group Health Plan for all other procedures.

Differences in benefits for services of Member/Participating/In-Network Providers and Non-Member/Non-Participating/Out-of-Network Providers will apply to our payments for multiple surgical procedures.

3. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Contract, Certificate or Group Health Plan ends may not include any of the benefits of this Rider.

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PATIENT PROTECTION AND AFFORDABLE CARE ACT RIDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes provisions in, or adds provisions to, your Contract, Certificate or Group Health Plan, including any affected riders or endorsements thereto, (hereinafter collectively "Health Plan") as required by the federal Patient Protection and Affordable Care Act. Except as otherwise provided in this Rider, the provisions herein apply to all persons covered under the Health Plan ("Members").

1. Emergency Services.

- A. **Emergency Condition Defined.** The definition of Emergency Condition in the Health Plan is hereby deleted in its entirety and replaced with the following:

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.

- B. **Emergency Services Defined.** The following definition is hereby added to your Health Plan:

Emergency Services. A medical screening examination (consisting of a clinical history, physical examination, diagnostic testing, and therapeutic interventions such as intravenous fluids and intravenous antibiotics) 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.

"To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility or to deliver a newborn child (including the placenta).

- C. **Prior Approval.** Emergency Services are not subject to prior authorization requirements.
- D. **Cost Sharing.** Any Copayment or Coinsurance requirement in the Health Plan that applies to Emergency Services provided by a Non-Participating Provider that differs from the Copayment or Coinsurance required for Emergency Services provided by a Participating Provider is hereby deleted and replaced with the Copayment or Coinsurance requirement, if any, applicable to Emergency Services provided by Participating Providers.

- E. **Your Payments.** You are responsible for any applicable Deductible, Copayment, or Coinsurance and for the Non-Participating Provider charges that exceed Our Payments.
2. **Preventive Services.** To the extent items and services in the sources referenced below are not already covered services for adults and children under the Health Plan, benefits for the items and services are hereby added to the Health Plan:
- A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;
 - B. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations; and
 - C. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").

Except as otherwise provided below with respect to contraceptive services, preventive services referenced above shall be covered in full when received from Participating Providers. The preventive services referenced above are only covered when provided by Participating Providers. Cost sharing (e.g., Copayments, Deductibles, Coinsurance) may apply to 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.

To the extent they are not already covered services for women under the Health Plan, benefits will be provided for the following contraceptive services: all FDA-approved contraceptive methods and sterilization procedures. FDA-approved contraceptive methods include prescription drugs and devices, and over-the-counter contraceptives when prescribed by a provider legally authorized to prescribe. The Health Plan will **only** provide covered in full benefits for oral contraceptives that are Generic Drugs and that are dispensed by Participating Pharmacies. If your Health Plan currently provides benefits for prescription drugs dispensed by a pharmacy, oral contraceptives that are Brand Name Drugs will be subject to applicable cost sharing under the Health Plan.

Benefits for contraceptive services will not be provided to Members covered under a Health Plan sponsored by a religious employer that has claimed an exemption from the requirement to provide coverage for such services under the Affordable Care Act. Employees of exempt religious employers may, however, be entitled to purchase coverage for contraceptive drugs and devices pursuant to New York law.

A list of the preventive services covered under this paragraph is available on our website at **excelluscbs.com**, or will be mailed to you upon request. You may request the list by calling the Customer Service number on your identification card.

3. **Annual Limits.** Any annual dollar limit under the Health Plan that applies to Essential Benefits, whether such annual limit applies only to an Essential Benefit or includes Essential Benefits and other benefits, is hereby deleted. "Essential Benefits" include ambulatory care; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative care; laboratory services; preventive and wellness services and chronic disease management; pediatric services including oral and vision care; and any other services set forth in regulations issued pursuant to the Patient Protection and Affordable Care Act.
4. **Pre-Existing Conditions.** Under this Rider, the provision, if any, in the Health Plan that allows us to exclude or otherwise limit coverage for Pre-Existing Conditions until a Member has been continuously covered under the Health Plan for a stated period is hereby deleted in its entirety with respect to all Members.
5. **Lifetime Dollar Limits Deleted.** Any lifetime dollar limit under the Health Plan is hereby deleted in its entirety.

6. **Dependent Children Covered to Age 26.** If the Health Plan makes coverage of dependents available, this Rider applies to coverage of children as follows:
- A. If you selected other than individual coverage, your children who are under the age of 26 may be covered under the Health Plan. Coverage lasts until the end of the month in which the child turns 26 years of age. 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 under this Rider.

Coverage for 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 not terminate while the Health 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's attaining age 26.
 - B. "Children" include your natural children, a legally adopted child; a step child; and a child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption period. Coverage lasts until the end of the month in which the child turns 26 years of age.
 - C. A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order is covered. Coverage lasts until the end of the month in which the child turns 26 years of age.
 - D. The provisions of any Rider to the Health Plan that extends coverage for young adults through age 29 (for example, the provision requiring that the child be unmarried) shall remain in effect for children ages 26 through 29 and are not changed by provisions set forth above in this Paragraph 6 that apply to children under the age of 26.
7. **Utilization Review.** The following changes are made to the Utilization Review paragraph in the Health Plan:
- A. The provision dealing with prospective urgent care claims in the Utilization Review paragraph in the Health Plan is hereby deleted in its entirety and replaced with the following:

With respect to prospective urgent claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 72 hours of receipt of the request. If we need additional information, we will request it within 24 hours of receipt of the request. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period. A claim or other matter is "urgent" if it could seriously jeopardize your life or health or the ability to regain maximum function; or if your provider determines that it is urgent, we must treat it as such.
 - B. The provision dealing with concurrent reviews in the Utilization Review paragraph in the Health Plan is hereby deleted in its entirety and replaced with the following:

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

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

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

- C. The paragraph in the Health Plan describing Notices of Adverse Determination is hereby deleted in its entirety and replaced with the following:

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

8. **External Appeal.** The External Appeal paragraph in the Health Plan is hereby deleted in its entirety and replaced with the following:

External Appeal.

- A. **External Appeal in General.** You have the right to an "external appeal" of certain coverage determinations made by us. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are accredited and are certified by the State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal. "Requested service" or "requested services" refers to the service or services for which you are requesting coverage.

You may have the right to an expedited external appeal if your attending physician attests that a delay in providing the requested service would pose an imminent or serious threat to your health or jeopardize your life, health, or ability to regain maximum function. Also, you have the right to an expedited external appeal in connection with 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. The timeframes for determining expedited external appeals are shorter than the timeframes for standard external appeals.

You may request an external appeal only if the requested service is a covered service under the Health Plan.

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

In general, you may not request an external appeal unless we have issued a "final adverse determination" of your request for coverage through the first level of the internal appeal process. However, if you qualify for an expedited external appeal, you may also file an expedited external appeal at the same time as filing an expedited internal appeal.

You may also ask us to agree to an external appeal even though you have not obtained a final adverse determination through the first level of the internal appeal process; however, we have no obligation to agree to your request. If we do agree, we will send you a letter stating that we have agreed to an external appeal even though you have not obtained a final adverse determination.

To be eligible for external appeal, the final adverse determination issued through the first level of the internal appeal process must be based on a determination that the requested service does not meet our 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. You do not have the right to an external appeal of any other determinations, even if those other determinations affect your coverage.

- C. **Conditions for External Appeals of Determinations of Medical Necessity.** You may request an external appeal of a final adverse determination of Medical Necessity issued through the first level of the internal appeal process if you meet the conditions of this subparagraph and the general requirements of Subparagraph B above. The provisions of this subparagraph apply only to external appeal of Medical Necessity determinations.

To request external appeal under this subparagraph, the final adverse determination must indicate that the requested service is not Medically Necessary. Subparagraph H below provides information on requesting an external appeal.

- D. **Conditions for External Appeals of Determinations Involving Experimental or Investigational Treatment.** This subparagraph governs external appeals of determinations involving experimental or investigational treatment. This subparagraph does not govern determinations involving services provided in clinical trials that are governed by Subparagraph E below.

In order to request an external appeal under this subparagraph, your attending physician must certify: that standard health services or procedures have been ineffective, or would be medically inappropriate in treating your condition or disease; or, that no more beneficial standard treatment exists which is a covered service under the Health Plan.

Your attending physician must have recommended a health service or procedure (including off-label usage of a pharmaceutical product) which, based on at least two documents from the available medical literature, is likely to be more beneficial to you than any standard covered health service or procedure. To make this recommendation, your attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat your condition or disease.

If you meet the requirements of this subparagraph and all of the requirements of Subparagraph B, you may request an external appeal. Subparagraph H provides information on requesting an external appeal.

- E. **External Appeals of Determinations Involving Clinical Trials.** This subparagraph governs external appeals of determinations involving services provided in clinical trials.

In order to request an external appeal under this subparagraph, your attending physician must certify that a clinical trial for your condition exists and that you are eligible to participate in the clinical trial.

Your attending physician must also recommend that you participate in the clinical trial. To make this recommendation, your attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat your condition or disease.

The clinical trial for which you are requesting coverage must be peer-reviewed, reviewed and approved by a qualified Institutional Review Board, and approved by one of the following:

- (1) The National Institutes of Health (NIH), an NIH cooperative group or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs;
- (2) An entity that has been identified by the NIH as a qualified non-governmental research entity; or
- (3) An Institutional Review Board of a facility that has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

If you meet the requirements of this subparagraph and all of the requirements of Subparagraph B, you may request an external appeal. Subparagraph H below provides information on requesting an external appeal.

- F. **External Appeals Involving Rare Diseases.** The following apply to external appeals involving Rare Diseases.

- (1) **Rare Disease Defined.** A condition or disease that:
 - (a) Is currently, or has been, subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or
 - (b) Affects less than 200,000 United States residents per year; and
 - (c) For which there does not exist a standard health service or procedure covered by your Health Plan that is more clinically beneficial than the requested health service or treatment.

- (2) **Certifying Physician.** The physician must be a licensed, board-certified or board-eligible physician who specializes in the area of practice appropriate to treat your Rare Disease.
- (3) **Conditions for External Appeals Involving Rare Disease Treatment.** In order to request an external appeal under this subparagraph, the following conditions must be met:
 - (a) **Certification.** A physician, other than your treating physician, who meets the requirements in Subparagraph (2) above, must certify in writing that:
 - (i) You have a Rare Disease as defined above.
 - (ii) That your Rare Disease is currently, or has been, subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or affects less than 200,000 United States residents per year.
 - (iii) Based on the physician's credible experience, there is no standard treatment that is likely to be clinically more beneficial to you than the requested health service or procedure; the requested health service or procedure is likely to benefit you in the treatment of your Rare Disease; and that such benefit to you outweighs the risks of such health service or procedure.
 - (b) **Required Disclosure by the Certifying Physician.** The certifying physician must disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for external appeal of a denial of your Rare Disease treatment.
 - (c) **Institutional Review Board.** If the provision of the requested health service or procedure at a facility requires prior approval of an institutional review board, you or your designee must submit such approval as part of the external appeal application.

G. **Effect of the External Appeal Agent's Decision; Coverage.** The decision of the External Appeal Agent is binding on both parties. If the External Appeal Agent decides in our favor, we will not cover the requested service. If the external appeal agent decides in your favor, we will cover the service as follows:

- (1) For services denied as not Medically Necessary, we will treat the service as Medically Necessary and provide coverage subject to all other conditions of the Health Plan.
- (2) For services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of the Health Plan.
- (3) For services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of the Health Plan. We are not required to pay for drugs or devices that are the subject of the clinical trial.
- (4) For services denied for treatment of a Rare Disease, we will provide coverage for the requested health service or procedure, subject to all other conditions of the Health Plan, when a majority of the panel of external appeal reviewers determines, based on the certification described in Subparagraph F.(3)(a) above, and such other evidence as you, your designee or your attending physician may present, that the requested health service or procedure is likely to benefit you in the treatment of your Rare Disease and that such benefit outweighs the risks of such health service or procedure.

We will not provide coverage for any service that is not a covered service under the Health Plan. In addition, this subparagraph does not alter any cost-sharing responsibilities as otherwise provided for in the Health Plan.

H. **Requesting an External Appeal.** If you meet the conditions described above, you may request an external appeal by filing a standard external appeal request form with the New York State Department of Financial Services. We will send a standard request form to you when we have made a final adverse determination at the first level of the internal appeal process. You or your physician may obtain additional standard request forms at any time from the State Department of Financial Services or by contacting us.

You must file your request for an external appeal with the State Department of Financial Services within four months of receiving a final adverse determination as a result of the first level appeal process, or within four months of receiving a letter from us waiving the internal review process. We do not have the authority to grant extensions of this deadline.

Additional internal appeals may be available to you which are optional. However, regardless of whether you participate in additional internal appeals, your application for external appeal must be filed with the New York State Department of Financial Services within 4 months from your receipt of the notice of final adverse determination from a first level internal appeal in order to be eligible for review by an external appeal agent.

You may be charged a fee of up to \$25 to request an external appeal (not to exceed \$75 in a single plan year), which may be waived if we determine that paying the fee is a financial hardship. The fee is returned if your external appeal is successful.

If you do not understand any part of the external appeal process or if you have questions regarding your right to external appeal, you may contact us or the State Department of Financial Services.

9. **Other Provisions.** All of the terms, conditions, and limitations of the Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



**RIDER TO CONTINUE COVERAGE FOR YOUNG ADULTS
THROUGH AGE 29**

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider allows eligible young adults to purchase coverage through your Contract, Certificate or Group Health Plan (collectively "Health Plan") and any applicable Rider(s) thereto. All of the terms, conditions and limitations of the Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Young Adults Covered through Age 29.** A young adult who no longer qualifies as a dependent under your Health Plan due to age will be eligible to continue coverage through the age of 29 years by independently purchasing coverage through your Health Plan subject to the conditions described below.
2. **Eligible Young Adults.** A young adult is eligible to continue coverage under this Rider when the young adult:
 - A. Is unmarried, and is the child of an employee or member insured under the Health Plan to which this Rider attaches;
 - B. Is not, as an employee or member, insured by or eligible for coverage under any employee health benefit plan, whether insured or self-insured;
 - C. Lives, works or resides in New York State; and
 - D. Is not covered under Medicare.


The young adult need not live with or be financially dependent upon you in order to purchase coverage under this Rider. In addition, a young adult's eligibility for coverage under federal COBRA or state continuation of coverage laws will not disqualify the young adult for coverage under this Rider.

3. **Young Adult Coverage must be Elected.** An employee, member or young adult who wishes to continue the young adult's coverage must request the continuation in writing:
 - A. Within 60 days following the date the young adult would otherwise lose eligibility for coverage because the young adult reached the age set forth in the Health Plan;
 - B. Within 60 days after the young adult meets the eligibility requirements set forth in Paragraph 2 above when the young adult's eligibility for coverage ended previously; or
 - C. During the open enrollment period for the Health Plan.
4. **Special Election Period.** There is a special election period for an employee, member or young adult who wishes to continue coverage for a young adult whose coverage under the Health Plan to which this Rider attaches terminated prior to the "effective date" of the law requiring the continued coverage described in this Rider. The "effective date" is the first date on or after September 1, 2009 that the Health Plan is renewed, modified, altered or amended. The special election period continues for a period of 12 months after the effective date.

5. **Effective Date of Continued Coverage.**
 - A. When continued coverage is elected under Subparagraph 3. A. above, the effective date of the continued coverage will be retroactive to the date eligibility for coverage would otherwise have ended.
 - B. When continued coverage is elected under Subparagraph 3. B or C above, or under Paragraph 4 above, the effective date of the continued coverage will be no later than 30 days after the election is made and the first premium is paid.
6. **Premium Payment.** The first premium payment must accompany the written election in order for continued coverage to take effect. Thereafter, the employee, member or young adult electing coverage must pay the full amount of the required premium on or before the due date of each payment. Any premium received within 30 days after the due date will be considered timely.
7. **Type of Coverage.** The continued coverage will be identical to the coverage that is provided to the employee or member parent. If the parent's coverage is modified, the young adult's continued coverage will be likewise modified.
8. **Termination of Coverage.** The continued coverage will end on the earliest of the following:
 - A. The date the young adult voluntarily terminates coverage under the Health Plan pursuant to its terms;
 - B. The date the young adult's parent is no longer covered under the Health Plan, including coverage provided under federal COBRA or state continuation of coverage laws;
 - C. The date the young adult becomes 30 years of age;
 - D. The date the young adult no longer meets the eligibility requirements set forth in Paragraph 2 above;
 - E. The date to which the last premium was paid if there is a failure to make the required premium payment before the end of the 30-day grace period; or
 - F. The date on which the group contract is terminated and not replaced.
9. **Effect of Termination of Continued Coverage.** When a young adult's continued coverage terminates, the young adult will not have an independent right to continue coverage under federal COBRA or state continuation of coverage laws.
10. **New Contract after Termination of Coverage May not Contain the Benefits of this Rider.** The new contract to which you may be entitled if your coverage under your Health Plan ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.
doing business as

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165 Court Street
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By: 

Christopher C. Booth
President and Chief Executive Officer



RIDER TO EXTEND TEMPORARY CONTINUATION OF COVERAGE

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider extends continued coverage available under your Contract, Certificate or Group Health Plan and any applicable Rider(s) thereto. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Continuation Period Extended to 36 Months.** Under this Rider, the 18-month period during which you are entitled to continue coverage under your Contract, Certificate or Group Health Plan pursuant to state law is extended to 36 months. The 29-month period during which you are entitled to continue coverage when determined to be disabled under Title II or XVI of the Social Security Act is also extended to 36 months.
2. **Coverage Available following Termination of federal COBRA Coverage.** Subject to the continuation provisions in your Contract, Certificate or Group Health Plan, and after you have exhausted your federal continuation benefits, you may continue coverage under the New York continuation of coverage law for: an additional 18 months when you are entitled to 18 months of federal COBRA coverage; and an additional seven months when you are entitled to 29 months of federal COBRA coverage.
3. **New Contract after Termination of Coverage May not Contain the Benefits of this Rider.** The new contract to which you may be entitled if your coverage under your Contract, Certificate or Group Health Plan ends may not include any of the benefits of this Rider.

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President and Chief Executive Officer



DENTAL CARE EXCLUSION RIDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes coverage under your Contract, Certificate or Group Health Plan (collectively, "Health Plan"). All of the terms, conditions and limitations of the Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

Dental Care Exclusion. The paragraph entitled "Dental Care" in the Exclusions Section of your Health Plan is hereby deleted in its entirety and replaced with the following:

Dental Care. We will not provide coverage for any service or care (including anesthesia and inpatient stays) for treatment of the teeth, gums, or structures supporting the teeth; or any form of dental surgery; regardless of the reasons(s) that the service or care is necessary. For example, we will not provide coverage for x-rays, fillings, extractions, braces, prosthetics, correction of impactions, treatments for gum disease, therapy or other treatments related to dental TMJ disorder or dental oral surgery. We will, however, provide the benefits set forth in your Health Plan for service and care for treatment of sound natural teeth provided within 12 months of an accidental injury. We do not consider an injury to a tooth caused by chewing or biting to be an accidental injury. We will also provide coverage for the services set forth in your Health Plan that we determine are Medically Necessary for treatment of a congenital anomaly or disease that was present at birth, such as cleft palate and ectodermal dysplasia. We will cover institutional provider services for dental care when we determine there is an underlying medical condition requiring these services.

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President and Chief Executive Officer



RIDER FOR INTER-PLAN ARRANGEMENTS DISCLOSURE

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider explains your liability for certain benefits covered under your Contract, Certificate or Group Health Plan (collectively "Health Plan"). All of the terms, conditions and limitations of the Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

Out-of-Area Services. We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area We serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Our Service Area, you will receive it from one of two kinds of providers. Most providers ("Participating Providers" or "In-Network Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("Nonparticipating Providers" or "Out-of-Network Providers") do not contract with the Host Blue. We explain below how We pay both kinds of providers.

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for dental care benefits other than those paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by Us to provide the specific service or services.

1. **BlueCard[®] Program.** Under the BlueCard Program, when you receive covered healthcare services within the geographic area served by a Host Blue, We will remain responsible for doing what We agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating/In-Network Providers.

When you receive covered healthcare services outside Our Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- A. The provider's billed covered charges for your covered services; or
- B. The negotiated price that the Host Blue makes available to Us. This negotiated price will be one of the following:
 - (1) Often, a simple discount that reflects an actual price that the Host Blue pays to your provider;
 - (2) 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
 - (3) Occasionally, an average price based on a discount that results in expected average savings for similar types of providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We have used for your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

2. **Calculation of Member Liability for Services of Non-Participating/Out-of-Network Providers outside Our Service Area.** The Allowable Expense definition in your Health Plan, as amended from time-to-time, describes how Our payment (the "Allowable Expense") for covered services of Non-Participating/Out-of-Network Providers outside Our Service Area is calculated. The Allowable Expense may be based upon the amount provided to Us by the Host Blue or the payment We would make to Non-Participating/Out-of-Network Providers inside Our 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, in addition to any other cost sharing amounts (Deductible, Copayment or Coinsurance) required by your Health Plan.
3. **BlueCard[®] Program Special Cases: Value-Based Programs.** If you receive covered healthcare services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are part of such an arrangement, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments. Additional information is available upon request.
4. **Blue Cross Blue Shield Global[®] Core.** If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of BCBS Global Core when accessing covered healthcare services. BCBS Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although BCBS Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the BCBS Global Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- A. In most cases, if you contact the BCBS Global Core service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-sharing amounts. In such cases, the hospital will submit your claims to BCBS Global Core service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services. You must contact Us to obtain precertification for non-emergency inpatient services.
- B. Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.
- C. When you pay for covered healthcare services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BCBS Global Core claim form and send the claim form with the provider's itemized bill(s) to the BCBS Global Core service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available for Us, the BCBS Global Core service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the BCBS Global Core service center at 1.800.810.BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

5. **BlueCard® Program Ancillary Services.** Under the BlueCard Program, when you access certain covered ancillary services (Laboratory, Durable Medical Equipment, or Specialty Pharmacy) within the geographic area ("Service Area") of a Host Blue, the provider may or may not be a Participating/In-Network Provider under the Host Blue's contracting arrangement. If the provider is a Participating/In-Network Provider, you will be responsible for the cost-sharing that applies to Participating/In-Network Providers. The provider is Participating/In-Network, and the Host Blue provider contracting arrangement applies, if:
- A. the Laboratory specimen is drawn at a location within the Host Blue's Service Area;
 - B. the Durable Medical Equipment (DME) is shipped to an address or purchased at a retail store located in the Host Blue's Service Area; or
 - C. the Physician prescribing an order for a Specialty Pharmacy is located in the Host Blue's Service Area.

Otherwise, the Host Blue provider contracting arrangement does not apply, and the provider is considered Non-Participating/Out-of-Network for the ancillary service. In that case, in addition to any cost-sharing that may apply to Non-Participating/Out-of-Network Providers, you may be responsible to the provider for the balance of the provider's charge.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
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By: 

Christopher C. Booth
President and Chief Executive Officer



**RIDER FOR PARITY IN
MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS**

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes or adds certain benefits for mental health and substance use disorder under your medical Contract, Certificate or Group Health Plan, including any applicable Rider(s) thereto. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Treatment Limitations.** We will provide benefits for visits by a physician or other covered professional provider while you are receiving inpatient care for mental health or substance use disorder subject to any treatment limitations that apply to benefits we provide for inpatient medical visits under your Contract, Certificate or Group Health Plan. For example: when we provide benefits for visits during unlimited days of inpatient medical and surgical care, we will provide benefits for visits during unlimited days of inpatient care for Mental Illness or substance use disorder; or when benefits for medical visits during inpatient care are subject to a day limit, that day limit will be applied, in the aggregate, to visits during inpatient medical care and inpatient care for mental health and substance use disorder.

The provider's services must be documented in the facility records.

Services of Participating and Non-Participating Providers will both be counted toward any day limits that apply to visits during inpatient stays for Mental Illness and substance use disorder.

- A. **Mental Health.** Coverage for visits for inpatient mental health care is subject to the following conditions and limitations:
 - (1) **Active Treatment.** We will provide benefits for visits during "active treatment" of Mental Illness. The term "active treatment" means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meets standards prescribed pursuant to the regulations of the Commissioner of Mental Health.
 - (2) **Covered Providers.** We will only provide coverage for visits by a: psychiatrist or psychologist licensed to practice in this state; licensed clinical social worker who meets the requirements of section 4303 (n) of the New York Insurance Law; professional corporation; or university faculty practice corporation.
 - (3) **Partial Hospitalization.** We will also provide coverage for visits while you are receiving care in a licensed partial hospitalization program. A partial hospitalization program is an ambulatory treatment program that provides a medically supervised alternative to inpatient treatment. One day's care in a partial hospitalization program will be considered inpatient care and will be counted as one-half of a day of care toward meeting the Single Confinement day limits that apply to visits during inpatient stays for Mental Illness.

B. Substance Use Disorder.

- (1) **Inpatient Detoxification.** We will provide coverage during active treatment for detoxification needed because of chemical dependence.
- (2) **Inpatient Chemical Dependence.** We will provide coverage during inpatient stays for diagnosis and active treatment for rehabilitation of chemical dependence and abuse. Inpatient rehabilitation services are designed to initiate the treatment and recovery process when you are unable to participate in or comply with treatment outside a 24-hour treatment setting.


We will provide benefits for office visits for diagnosis and treatment of Mental Illness subject to treatment limitations that apply to benefits we provide for visits for diagnosis and/or treatment of medical conditions under your Contract, Certificate or Group Health Plan. This means that we will provide benefits for unlimited visits for diagnosis and treatment of Mental Illness. We will only provide benefits for services of a: psychiatrist or psychologist licensed to practice in this state; licensed clinical social worker who meets the requirements of section 4303 (n) of the New York Insurance Law; professional corporation; or university faculty practice corporation.

2. **Financial Requirements.** Benefits under this Rider are subject to the predominant level of cost-sharing that applies to benefits for medical care under your Contract, Certificate or Group Health Plan. For example, the predominant level of cost-sharing (any Deductible, Copayment or Coinsurance) that applies to inpatient medical visits will apply to benefits for inpatient mental health and substance use disorder visits under this Rider; and the predominant level of cost-sharing (any Deductible, Copayment or Coinsurance) that applies to outpatient benefits will apply to office visits for diagnosis and treatment of Mental Illness under this Rider.
3. **Services Not Covered.** Nothing in this Rider shall be construed to provide benefits for mental health services: for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or to a custodial facility for youth operated by the office of children; solely because such services are court-ordered; that are cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs; or for mental health or substance use disorder services that are otherwise excluded under your Contract, Certificate or Group Health Plan.
4. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Contract, Certificate or Group Health Plan ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.

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By: 

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President and Chief Executive Officer



RIDER FOR PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes or adds certain benefits for mental health and substance use disorder under your hospital Contract, Certificate or Group Health Plan, including any applicable Rider(s) thereto. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Treatment Limitations.**

- A. **Inpatient Care.** We will provide benefits for inpatient care for mental health and substance use disorder subject to any treatment limitations that apply to benefits we provide for inpatient medical and surgical care under your Contract, Certificate or Group Health Plan. For example: when we provide benefits for unlimited days of inpatient medical and surgical care, we will provide benefits for unlimited days of inpatient care for Mental Illness or substance use disorder; or when benefits for inpatient medical and surgical care are subject to a day limit, that day limit will be applied, in the aggregate, to inpatient medical and surgical care and inpatient care for mental health and substance use disorder.

Services of Participating and Non-Participating Providers will be both counted toward any day limits that apply to inpatient care for Mental Illness and for substance use disorder.

We will provide coverage as follows:

- (1) **Mental Health.** We will provide benefits for "active treatment" of Mental Illness. The term "active treatment" means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meets standards prescribed pursuant to the regulations of the Commissioner of Mental Health. We will only provide coverage in a Facility that is a hospital as defined by subdivision ten of section 1.03 of the New York Mental Hygiene Law. A hospital does not include a: residential treatment program; group home; school; camp; halfway house; or other supportive housing.

We will also provide coverage for care in a licensed partial hospitalization program. A partial hospitalization program is an ambulatory treatment program that provides a medically supervised alternative to inpatient treatment. One day's care in a partial hospitalization program will be considered inpatient care and will be counted as one-half of a day of care toward meeting any day limits that apply to inpatient care for Mental Illness.

(2) **Substance Use Disorder.**

- (a) **Inpatient Detoxification.** We will provide coverage for active treatment for detoxification needed because of chemical dependence. This coverage is available only for services rendered in and billed by:
- (i) A Facility in New York State which is certified by the Office of Alcoholism and Substance Abuse Services;
 - (ii) A program we recognize as a chemical dependence and abuse treatment program; or
 - (iii) A Facility in another state that we recognize is approved by JCAHO as an alcoholism or chemical dependence and abuse treatment program and meets the appropriate state licensing. If a government hospital meets these criteria, services rendered there will be covered unless no charge would have been made in the absence of coverage under your Contract, Certificate or Group Health Plan.
- (b) **Inpatient Chemical Dependence and Abuse Rehabilitation.** We will provide coverage for the diagnosis and active treatment for rehabilitation of chemical dependence and abuse. Inpatient rehabilitation services are designed to initiate the treatment and recovery process when you are unable to participate in or comply with treatment outside a 24-hour structured treatment setting. Nursing services are available 24 hours per day. Inpatient treatment includes management of any of your physical or mental complications or co-morbidities. We will provide coverage for these medically-supervised services in a Facility that is a Plan approved provider for the active rehabilitation and treatment of chemical dependency. We will not provide benefits for intensive residential, community residential or supportive living services.

B. **Outpatient Care.** We will provide benefits for outpatient care for Mental Illness and substance use disorder subject to treatment limitations that apply to benefits we provide for outpatient medical and surgical care under your Contract, Certificate or Group Health Plan. This means that we will provide benefits for unlimited visits for diagnosis and treatment of Mental Illness as described in Subparagraph (1) below; and we will provide benefits for unlimited visits of the type described in Subparagraph (2) below for diagnosis and treatment of chemical dependency.

- (1) **Mental Health.** We will provide benefits: in a facility that has an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law or in a facility operated by the Office of Mental Health.
- (2) **Chemical Dependency.** We will provide coverage for outpatient visits in a Facility. Each individual visit must consist of at least one of the following: individual or group chemical dependence counseling; activity therapy; and diagnostic evaluations by a Professional Provider to determine the nature and extent of your illness or disability. We will not provide coverage for visits that consist primarily of participation in programs of a social, recreational, or companionship nature.

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

2. **Financial Requirements.** Benefits under this Rider are subject to the predominant level of cost-sharing that applies to benefits for medical and surgical care under your Contract, Certificate or Group Health Plan. For example, the predominant level of cost-sharing (any Deductible, Copayment or Coinsurance) that applies to inpatient medical and surgical care will apply to inpatient mental health and substance use disorder benefits under this Rider; and the predominant level of cost-sharing (any Deductible, Copayment or Coinsurance) that applies to outpatient benefits will apply to outpatient visits for diagnosis and treatment of Mental Illness and substance use disorder under this Rider.
3. **Services Not Covered.** Nothing in this Rider shall be construed to provide benefits for mental health services: for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or to a custodial facility for youth operated by the office of children; solely because such services are court-ordered; that are cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs; or for mental health or substance use disorder services that are otherwise excluded under your Contract, Certificate or Group Health Plan.
4. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Contract, Certificate or Group Health Plan ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.
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By: 

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR EXTERNAL APPEALS INVOLVING RARE DISEASES

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds new requirements to the External Appeal provision in your Contract, Certificate or Group Health Plan and any applicable Rider(s) thereto. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

External Appeals Involving Rare Diseases. The following apply to external appeals involving Rare Diseases.

1. **Rare Disease Defined.** A life-threatening or disabling condition or disease that:
 - A. Is currently, or has been, subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or
 - B. Affects less than 200,000 United States residents per year; and
 - C. For which there does not exist a standard health service or procedure covered by your Contract, Certificate or Group Health Plan that is more clinically beneficial than the requested health service or treatment.
2. **Certifying Physician.** The physician must be a licensed, board-certified or board-eligible physician who specializes in the area of practice appropriate to treat your Rare Disease.
3. **Conditions for External Appeals Involving Rare Disease Treatment.** In order to request an external appeal under this Rider, the following conditions must be met:
 - A. **Certification.** A physician, other than your treating physician, who meets the requirements in Paragraph 2 above, must certify in writing that:
 - (1) You have a Rare Disease as defined above.
 - (2) That your Rare Disease is currently, or has been, subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or affects less than 200,000 United States residents per year.

- (3) Based on the physician's credible experience, there is no standard treatment that is likely to be clinically more beneficial to you than the requested health service or procedure; the requested health service or procedure is likely to benefit you in the treatment of your Rare Disease; and that such benefit to you outweighs the risks of such health service or procedure.
- B. **Required Disclosure by the Certifying Physician.** The certifying physician must disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for external appeal of a denial of your Rare Disease treatment.
- C. **Institutional Review Board.** If the provision of the requested health service or procedure at a facility requires prior approval of an institutional review board, you or your designee must submit such approval as part of the external appeal application.
4. **Effect of the External Appeal Agent's Decision; Coverage.** We will provide coverage for the requested health service or procedure according to the terms, conditions and limitations of your Contract, Certificate or Group Health Plan when a majority of the panel of external appeal reviewers determines, based on the certification described in Subparagraph 3. A. above, and such other evidence as you, your designee or your attending physician may present, that the requested health service or procedure is likely to benefit you in the treatment of your Rare Disease, and that such benefit outweighs the risks of such health service or procedure.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



**RIDER FOR EXTERNAL APPEALS INVOLVING RARE DISEASES
AND PRIOR APPROVAL OF HOME CARE SERVICES**

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds new requirements to the External Appeal and Prior Approval provisions in your Contract, Certificate or Group Health Plan and any applicable Rider(s) thereto. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **External Appeals Involving Rare Diseases.** The following apply to external appeals involving Rare Diseases.
 - A. **Rare Disease Defined.** A life-threatening or disabling condition or disease that:
 - (1) Is currently, or has been, subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or
 - (2) Affects less than 200,000 United States residents per year; and
 - (3) For which there does not exist a standard health service or procedure covered by your Contract, Certificate or Group Health Plan that is more clinically beneficial than the requested health service or treatment.
 - B. **Certifying Physician.** The physician must be a licensed, board-certified or board-eligible physician who specializes in the area of practice appropriate to treat your Rare Disease.
 - C. **Conditions for External Appeals Involving Rare Disease Treatment.** In order to request an external appeal under this Rider, the following conditions must be met:
 - (1) **Certification.** A physician, other than your treating physician, who meets the requirements in Subparagraph B above, must certify in writing that:
 - (a) You have a Rare Disease as defined above.
 - (b) That your Rare Disease is currently, or has been, subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or affects less than 200,000 United States residents per year.
 - (c) Based on the physician's credible experience, there is no standard treatment that is likely to be clinically more beneficial to you than the requested health service or procedure; the requested health service or procedure is likely to benefit you in the treatment of your Rare Disease; and that such benefit to you outweighs the risks of such health service or procedure.

- (2) **Required Disclosure by the Certifying Physician.** The certifying physician must disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for external appeal of a denial of your Rare Disease treatment.
- (3) **Institutional Review Board.** If the provision of the requested health service or procedure at a facility requires prior approval of an institutional review board, you or your designee must submit such approval as part of the external appeal application.

D. **Effect of the External Appeal Agent's Decision; Coverage.** We will provide coverage for the requested health service or procedure according to the terms, conditions and limitations of your Contract, Certificate or Group Health Plan when a majority of the panel of external appeal reviewers determines, based on the certification described in Subparagraph C. (1) above, and such other evidence as you, your designee or your attending physician may present, that the requested health service or procedure is likely to benefit you in the treatment of your Rare Disease, and that such benefit outweighs the risks of such health service or procedure.

2. **Approval of Home Care Services following an Inpatient Admission.**

- A. **When we will make a Determination.** After receiving a request for approval of home care services following an inpatient admission, we will review the reasons for your planned home care services and determine if benefits are available. We will notify you and your Professional Provider of our decision by telephone and writing: within one business day of receipt of all necessary information; or, when the day subsequent to the request falls on a weekend or holiday, within 72 hours of receipt of all necessary information.
- B. **Requests prior to Discharge.** When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home care services, either on the basis of Medical Necessity or for failure to obtain prior authorization, while our decision on the request is pending.
- C. **Internal Appeals of Adverse Determinations.** We will handle the review of an appeal of an adverse determination of a home care prior approval request on an expedited basis. For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours after receipt of the appeal request. Our failure to render a determination of your expedited appeal within two business days of receipt of the information necessary to conduct the appeal shall be deemed a reversal of the initial adverse determination.

If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal as described in your Contract, Certificate or Group Health Plan. Our failure to render a determination of your internal appeal within 60 calendar days shall be deemed a reversal of the initial adverse determination.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR GRIEVANCE PROCEDURES AND TRANSITIONAL CARE

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider to your Contract, Certificate or Group Health Plan (collectively "Health Plan") explains our grievance procedures and eligibility requirements for transitional care. All of the terms, conditions and limitations of the Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Grievance Procedures.** We maintain procedures to resolve your grievances. These procedures make sure that we resolve your questions, concerns, and complaints in a timely, fair manner.
 - A. **Filing a First-Level Grievance.** Our Grievance Procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by us. To initiate a grievance, just contact us. We keep all requests and discussions confidential and we'll take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry. We maintain a file on each grievance.

You can either contact our Customer Service Department by phone (at the Customer Service number shown on your ID card), in person or in writing (at the address shown below on this Rider) to file a grievance. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

When we receive your first-level grievance, we'll mail an acknowledgment letter within 15 business days. This acknowledgment letter will include the name, address and telephone number of the person handling your grievance, and indicate what additional information, if any, must be provided.

We will decide your first-level grievance and notify you of our determination in writing within 30 calendar days of receipt of your grievance request.

If your first-level grievance relates to an urgent matter, we'll decide the grievance and notify you of our determination by phone within 48 hours of receipt of your first-level grievance request. Written notice will follow within 24 hours of our determination.

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

- B. **Filing a Second-Level Grievance (Appeal).** If you're not satisfied with the resolution of the first-level grievance, you or your designee may file a second-level grievance by phone (at the Customer Service number shown on your ID card), in person, or in writing (at the address shown below on this Rider). You have up to 180 calendar days from receipt of the first-level grievance determination to file a second-level grievance. One or more qualified personnel at a higher level than the personnel who rendered the first-level grievance determination will review it, or if it's a clinical matter, a clinical peer reviewer will look into it.

When we receive your second-level grievance, we'll mail an acknowledgment letter within 15 calendar days. This acknowledgement letter will include the name, address, and telephone number of the person handling your grievance and indicate what additional information, if any, must be provided.

We'll decide the second-level grievance and notify you of our determination in writing within 30 calendar days of receipt of your second-level grievance request.

If your second-level grievance relates to an urgent matter, we'll decide the second-level grievance and notify you of our determination by phone within 24 hours of receipt of your second-level grievance request. Written notice will follow within 24 hours of our determination.

- C. **Notice of Determination.** The notice of determination of both your first-level and second-level grievances will include detailed reasons for the determination or a written statement that insufficient information was presented or available to reach a determination, and further appeal rights, if any. When a clinical matter is involved, the clinical rationale will be included with the notice. We will send notices to you or your representative and to your health care provider.

If you remain dissatisfied with our first-level and/or second level grievance determinations, or at any other time you are dissatisfied, you may:

Call the New York State Department of Insurance at 1-800-342-3736 or write them at:

New York State Department of Insurance
Consumer Services Bureau
One Commerce Plaza
Albany, NY 12257
www.ins.state.ny.us

2. **Transitional Care.** The following provisions apply to transitional care requirements.
- A. **Existing Members.** If your current provider no longer participates in our network, for reasons other than quality of care, you may continue treatment with this provider for up to 90 days from the date your provider's contractual obligation ends if you are already in an ongoing course of treatment.
- B. **New Members.** If you're a new Member with a life-threatening disease or condition, or a degenerative and disabling disease or condition, and the provider you currently see does not participate in our provider network, you may request to continue treatment with that provider for 60 days from your enrollment in our Health Plan.
- C. **Pregnant Women.** If you are a pregnant woman in your second or third trimester, you may continue with your provider (in either the case of a provider termination or a new Member enrollment) through a transitional period during which you may receive any postpartum care directly related to the pregnancy.
- D. **Provider Requirements.** To continue with a non-participating provider in any of the situations described in Subparagraphs A., B., and C. above, the provider must: accept our reimbursement as payment in full; adhere to our quality assurance program; agree to provide us with necessary medical information related to care; and follow our policies and procedures.

To request transitional care, you may ask your doctor to contact us, or you may call us directly.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



DOMESTIC PARTNER RIDER FOR CALIFORNIA RESIDENTS

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds coverage for domestic partners to your Contract, Certificate or Group Health Plan, including any affected Riders thereto (hereinafter collectively "Health Plan"). All of the terms, conditions and limitations of the Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **California Residency Required.** This Rider only applies to residents of the State of California. You, the Subscriber, are only entitled to cover your domestic partner as described in this Rider if you reside in California.
2. **Who are Domestic Partners?** Domestic partners are two persons who are registered as domestic partners, which means they have filed a "Declaration of Domestic Partnership" with the California Secretary of State. You are eligible to register as domestic partners if you meet the following criteria: you are both 18 years of age or older; you are unrelated by blood in a way that would bar marriage in the State of California; you reside together; you are persons of the same sex, or one or both of you is over the age of 62; and neither of you is married to someone else or is in a domestic partnership with someone else.
3. **Domestic Partner Coverage.** Coverage of your, the Subscriber's, domestic partner will become effective and terminate according to the provisions in your Health Plan that apply to coverage of the Subscriber's spouse. All of the terms of your Health Plan that apply to a spouse will apply to your domestic partner, except that according to federal law, domestic partners are not eligible for continuation of coverage under COBRA.
4. **New Contract After Termination of Coverage May Not Contain the Benefits of this Rider.** The new contract to which you may be entitled if your coverage under your Health Plan ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR NEW CONTRACT AFTER TERMINATION

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes the "Right to New Contract after Termination" section of your Certificate or Group Health Plan. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

Under this Rider, the paragraph called "The New Contract" in the "Right to New Contract after Termination" section of your Certificate or Group Health Plan is deleted in its entirety and replaced with the following:

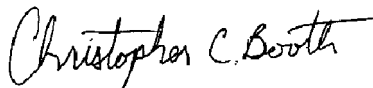
The New Contract. We will offer You an individual direct payment contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. You may choose among any of the four contracts offered by Us. However, the coverage may not be the same as Your current coverage. If you are age 65 or over, the new contract will be one of the contracts issued to Medicare-eligible applicants.

New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider. The new contract to which you may be entitled if your coverage under your Certificate or Group Health Plan ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR AUTISM SPECTRUM DISORDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider provides certain benefits for autism spectrum disorder under your Contract, Certificate, or Group Health Plan, including any affected riders or endorsements thereto, (hereinafter collectively "Health Plan"). All of the terms, conditions, and limitations of the Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Autism Spectrum Disorder.** We 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 by us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this Rider, "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).

A. **Screening and Diagnosis.** We will provide coverage for assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

B. **Assistive Communication Devices.** We will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we will provide coverage 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. We will also cover 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. We 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, we will cover 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 the additional cost of equipment or accessories that are not Medically Necessary. We will not provide coverage for delivery or service charges or for routine maintenance.

Prior approval of assistive communication devices is required. Refer to the prior approval procedures in your Health Plan.

C. **Behavioral Health Treatment.** We will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed provider. We will provide coverage for applied behavior analysis 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.** We will provide coverage 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.** We will provide coverage for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when 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 your Health 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 Health Plan.
- F. **Pharmacy Care.** We will provide coverage for prescription drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under title eight of the Education Law when prescription drugs are otherwise covered under your Health Plan. Our coverage of such prescription drugs is subject to all the terms, provisions, and limitations that apply to prescription drug benefits under your Health Plan.

We 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 the Education Law.

You are responsible for any applicable Deductible, Copayment, or Coinsurance provisions under your Health Plan for similar services. For example, any Deductible, Copayment, or Coinsurance that applies to physical therapy visits generally will also apply to physical therapy services covered under this Rider; and any Deductible, Copayment, or Coinsurance for prescription drugs generally will also apply to prescription drugs covered under this Rider. Any Deductible, Copayment, or Coinsurance that applies to physician medical services will apply to assistive communication devices covered under this Rider.

- 2. **New Contract After Termination of Coverage May Not Contain the Benefits of This Rider.** The new contract to which you may be entitled if your coverage under your Health Plan ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



CERTIFICATE RIDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

The following provisions of the Mental Health Care and Substance Use Disorders or Chemical Dependency and Abuse Rehabilitation sections of Your Certificate are hereby amended.

Mental Health Care and Substance Use Services

A. Mental Health Care Services.

1. Inpatient Services. We Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. 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:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- A state or local government run psychiatric inpatient Facility;
- 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;
- 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.

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

2. **Outpatient Services.** We Cover 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, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; or a professional corporation or a university faculty practice corporation thereof.
3. **Limitations/Terms of Coverage.** We do not Cover:
 - Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
 - Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the New York State Office of Children and Family Services; or
 - Services solely because they are ordered by a court.

B. Substance Use Services.

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

We also Cover inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities defined in 14 NYCRR 819.2(a)(1) and to services provided in such Facilities in accordance with 14 NYCRR Parts 817 and 819; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency, including methadone treatment. Such Coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

We also Cover unlimited outpatient visits per calendar year 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 substance use and/or dependency; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use and/or dependency. Our 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.

All of the terms, conditions, limitations, and exclusions of Your Certificate, including the cost-sharing provisions relating to mental health and substance abuse benefits, to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR NON-PARTICIPATING COVERAGE AND "SURPRISE BILLS"

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes provisions in, or adds provisions to your Certificate of Coverage, including any affected riders or endorsements thereto, for non-participating coverage and "surprise bills". All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

A. Protection from Surprise Bills. A surprise bill is a bill You receive for covered services provided on and after March 31, 2015 in the following circumstances:

1. For services performed by a non-participating physician at a participating Hospital or ambulatory surgical center, when:
 - a. A participating physician is unavailable at the time the health care services are performed;
 - b. A non-participating physician performs services without Your knowledge; or
 - c. Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating physician is available and You elected to receive services from a non-participating physician.

2. You were referred by a participating physician to a Non-Participating Provider without Your explicit written consent acknowledging that the authorization is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, an authorization to a Non-Participating Provider means:
 - a. Covered services are rendered by a Non-Participating Provider in the participating physician's office or practice during the same visit; or
 - b. The participating physician sends a specimen taken from You in the participating physician's office to a non-participating laboratory or pathologist.
 - c. For any other Covered services performed by a Non-Participating Provider at the participating physician's request, when authorizations are required under Your Certificate.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Copayment, Deductible or Coinsurance if You assign benefits to the Non-Participating Provider in writing. In such cases, the Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at www.excellusbcbs.com for a copy of the form. You need to mail a copy of the assignment of benefits form to Us at the address on Your ID card and to Your Provider.

3. **Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.
- B. Authorization to a Non-Participating Provider.** Effective on the date of issuance or renewal of this Certificate on or after March 31, 2015, if We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve an authorization to an appropriate Non-Participating Provider. Your Participating Provider or You must request prior approval of the authorization to a specific Non-Participating Provider. Approvals of authorizations to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your physician, the Non-Participating Provider and You. Covered services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable cost-sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will be covered as an out-of-network benefit, if available.
- C. No Assignment.** Under this Rider, the No Assignment paragraph in the General Provisions Section of Your Certificate is hereby deleted in its entirety and replaced with the following:
- Assignment.** You cannot assign any benefits under this Certificate to any person, corporation or other organization. You cannot assign any monies due under this Certificate to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill. Any assignment by You other than for monies due for a surprise bill will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services.
- D. Notice of Claim.** Under this Rider, the following paragraph is added to the General Provisions Section of Your Certificate:
- Notice of Claim.** Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your identification card or visiting Our website at www.excellusbcb.com. Completed claim forms should be sent to the address on Your identification card. Effective on the date of issuance or renewal of this Certificate on or after March 31, 2015, You may also submit a claim to Us electronically by visiting Our website at www.excellusbcb.com.
- E. Utilization Review.** Under this Rider, the Utilization Review paragraph in the General Provision Section of your Certificate is hereby deleted in its entirety and replaced with the following:
1. **Utilization Review.** We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (prior authorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your identification card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.
- All determinations that services are not Medically Necessary will be made by: 1) licensed physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to substance use disorder treatment, effective on the date of issuance or renewal of this Certificate on or after

March 31, 2015, licensed physicians or licensed, certified, registered or credentialed health care professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your identification card.

2. **Prior Authorization Reviews.**

- a. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a prior authorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

- b. **Urgent Prior Authorization Reviews.** With respect to urgent prior authorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period.

3. **Concurrent Reviews.**

- a. **Non-Urgent Concurrent Reviews.** Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within one (1) business day of the end of the 45-day time period.

- b. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

- c. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business

day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient Hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

- d. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.
4. **Retrospective Reviews.** If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.
5. **Retrospective Review of Prior Authorized Services.** We may only reverse a prior authorized treatment, service or procedure on retrospective review when:
 - a. The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the prior authorization review;
 - b. The relevant medical information presented to Us upon retrospective review existed at the time of the prior authorization but was withheld or not made available to Us;
 - c. We were not aware of the existence of such information at the time of the prior authorization review; and
 - d. Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the prior authorization review.
6. **Reconsideration.** If We did not attempt to consult with Your Provider who recommended the covered service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For prior authorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.
7. **Utilization Review Internal Appeals.** You, Your designee, and, in retrospective review cases, Your Provider, may request an internal appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an appeal. We will acknowledge Your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your appeal and, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a physician or a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

- a. **Non-Participating Service Denial.** Effective on the date of issuance or renewal of this Certificate on or after March 31, 2015, You also have the right to appeal the denial of a prior authorization request for a non-participating health service when We determine that the non-participating health service is not materially different from an available participating health service. A denial of a non-participating health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. You are not eligible for a Utilization Review appeal if the service You request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating Your condition. (Such an appeal will be treated as a grievance.) For a Utilization Review appeal of denial of a non-participating health service, You or Your designee must submit:
 - i. A written statement from Your attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested non-participating health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
 - ii. Two (2) documents from the available medical and scientific evidence that the non-participating service: 1) is likely to be more clinically beneficial to You than the participating alternate service; and 2) that the adverse risk of the non-participating service would likely not be substantially increased over the participating health service.
- b. **Non-Participating Authorization Denial.** Effective on the date of issuance or renewal of this Certificate on or after March 31, 2015, You also have the right to appeal the denial of a request for an authorization to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review appeal of a non-participating authorization denial, You or Your designee must submit a written statement from Your attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
 - i. That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
 - ii. Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

8. **Standard Appeal.**

- a. **Prior authorization Appeal.** If Your appeal relates to a prior authorization request, We will decide the appeal within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.
- b. **Retrospective Appeal.** If Your appeal relates to a retrospective claim, We will decide the appeal within 60 calendar days of receipt of the appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.
- c. **Expedited Appeal.** An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited appeal is not available for retrospective reviews. For an expedited appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one (1) business day of receipt of the request for an appeal. Your Provider and a clinical peer

reviewer may exchange information by telephone or fax. An expedited appeal will be determined within the earlier of 72 hours of receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal.

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

Our failure to render a determination of Your appeal within 60 calendar days of receipt of the necessary information for a standard appeal or within two (2) business days of receipt of the necessary information for an expedited appeal will be deemed a reversal of the initial adverse determination.

- d. **Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or your Provider file an expedited internal appeal of Our adverse determination, We will decide the appeal within 24 hours of receipt of the appeal request. If You or Your Provider file the expedited internal appeal and an expedited external appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal appeal and external appeal is pending.
- e. **Appeal Assistance.** If You need assistance filing an appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
www.communityhealthadvocates.org

F. External Appeal. Under this Rider, the External Appeal paragraph in the General Provision Section of your Certificate is hereby deleted in its entirety and replaced with the following:

- 1. **Your Right to an External Appeal.** In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is a non-participating treatment, You or Your representative may appeal that decision to an external appeal agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- a. The service, procedure, or treatment must otherwise be a covered service under this Certificate; and
 - b. In general, You must have received a final adverse determination through Our internal appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal appeal process if:
 - i. We agree in writing to waive the internal appeal. We are not required to agree to Your request to waive the internal appeal; or
 - ii. You file an external appeal at the same time as You apply for an expedited internal appeal; or
 - iii. We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).
- 2. **Your Right to Appeal a Determination that a Service is Not Medically Necessary.** If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an external appeal agent if You meet the requirements for an external appeal in paragraph "1" above.

3. **Your Right to Appeal a Determination that a Service is Experimental or Investigational.** If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "1" above and Your attending physician must certify that Your condition or disease is one for which:
- Standard health services are ineffective or medically inappropriate; or
 - There does not exist a more beneficial standard service or procedure covered by Us; or
 - There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending physician must have recommended one (1) of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard covered service (only certain documents will be considered in support of this recommendation - Your attending physician should contact the State for current information as to what documents will be considered or acceptable); or
- A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which Your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending physician may not be Your treating physician.

4. **Your Right to Appeal a Determination that a Service is Non-Participating.** Effective on the date of issuance or renewal of this Certificate on or after March 31, 2015, if We have denied coverage of non-participating treatment because it is not materially different than the participating health service available, You may appeal to an external appeal agent if You meet the two (2) requirements for an external appeal in paragraph "1" above, and You have requested prior authorization for the non-participating treatment.

In addition, Your attending physician must certify that non-participating service is materially different from the participating alternate recommended health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the participating alternate treatment and that the adverse risk of the requested health service would likely not be substantially increased over the participating alternate health service.

For purposes of this section, Your attending physician must be a licensed, board certified or board eligible physician qualified to practice in the specialty area appropriate to treat You for the health service.

If the date of issuance or renewal of this Certificate is prior to March 31, 2015, You do not have a right to an external appeal for a denial of an authorization to Non-Participating Provider on the basis that a Participating Provider is available in-network to provide the particular health service requested by You.

5. **Your Right to Appeal a Non-Participating Authorization Denial.** Effective on the date of issuance or renewal of this Certificate on or after March 31, 2015, if We have denied coverage of a request for an authorization to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an external appeal agent if You meet the two (2) requirements for an external appeal in paragraph "1" above.

In addition, Your attending physician must: certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending physician must be a licensed, board certified or board eligible physician qualified to practice in the specialty area appropriate to treat You for the health service.

- 6. The External Appeal Process.** You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal appeal process or Our written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You can submit additional documentation with Your external appeal request. If the external appeal agent determines that the information You submit represents a material change from the information on which We based Our denial, the external appeal agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the external appeal agent must make a decision within 30 days of receipt of Your completed application. The external appeal agent may request additional information from You, Your physician, or Us. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify You in writing of its decision within two (2) business days.

If Your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the external appeal agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the external appeal agent must notify You and Us by telephone or facsimile of that decision. The external appeal agent must also notify You in writing of its decision.

If the external appeal agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or a non-participating treatment, We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

The external appeal agent's decision is binding on both You and Us. The external appeal agent's decision is admissible in any court proceeding.

We will charge You a fee of up to \$25 for each external appeal, not to exceed \$75 in a single Calendar Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the external appeal agent overturns the denial of coverage, the fee will be refunded to You.

7. **Your Responsibilities.** It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.


Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

- H. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under Your Certificate ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



**RIDER FOR DELIVERY OF COVERED SERVICES USING
TELEHEALTH AND TELEMEDICINE PROGRAM**

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds the "Delivery of Covered Services Using Telehealth" and "Telemedicine Program" sections to your Certificate. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. Delivery of Covered Services Using Telehealth.

If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

2. Telemedicine Program.

We Cover online internet consultations between You and Providers who participate in Our telemedicine program for medical conditions that are not an Emergency Condition. Not all Participating Providers participate in Our telemedicine program. You can check Our Provider directory or contact Us for a listing of the Providers that participate in Our telemedicine program.

The telemedicine program is the delivery of healthcare services through the use of privacy compliant technology. Telemedicine visits allow You to connect with a Provider via video conference, or telephone for the purposes of diagnosis, consultation and treatment; just as would be provided during a face to face office visit. You will be responsible for the applicable Deductible, Copayment or Coinsurance.

3. New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider. The new contract to which you may be entitled if your coverage under your Certificate ends may not include any of the benefits of this Rider.

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Rochester, NY 14647

By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR MEMBER DISCOUNT PROGRAMS

Issued by

EXCELLUS HEALTH PLAN, INC.

A Nonprofit Independent Licensee of the BlueCross BlueShield Association

This Rider adds certain benefits to your Certificate of Coverage ("Certificate"). All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Member Discount Programs**

We have agreements with various vendors that provide Members with various discounts on the products and services they offer. Discounts are available primarily for health-related services, such as fitness centers, hearing aids, vitamins, weight loss programs, childbirth classes, and dental and vision services. Discounts will not be available if a service is an otherwise Covered benefit under the Certificate. You can view the discounts available to You by visiting Our website at www.excellusbcbbs.com. You must present your identification card to the vendor at the time a service is purchased. The vendor will then apply the applicable discount.

2. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Certificate ends may not include any of the benefits of this Rider.

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By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR COURT ORDERED TREATMENT

Issued by

EXCELLUS HEALTH PLAN, INC.

A Nonprofit Independent Licensee of the BlueCross BlueShield Association

This Rider adds certain benefits for Court Ordered Treatment to Your Certificate of Coverage and any affected Riders thereto. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

The provision dealing with Prospective Reviews under the Utilization Review paragraph is hereby amended with the following:

Court Ordered Treatment.

Effective on the date of issuance or renewal of this Certificate on or after April 1, 2016, with respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

The provision dealing with Expedited Appeals under the Utilization Review paragraph is hereby amended with the following:

Expedited Appeal.

An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a provider requests an immediate review effective on the date of issuance or renewal of this Certificate on or after April 1, 2016 mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited appeal is not available for retrospective reviews. For expedited appeals, Your Provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one (1) business day of receipt of the request for an appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited appeal will be determined within the earlier of 72 hours of receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal.

Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider. The new contract to which You may be entitled if your coverage under Your Certificate ends may not include any of the benefits of this Rider.

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165 Court Street
Rochester, NY 14647

By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR CONVERSION THERAPY

Issued by

EXCELLUS HEALTH PLAN, INC.

A Nonprofit Independent Licensee of the BlueCross BlueShield Association

This Rider excludes coverage for Conversion Therapy from Your Certificate of Coverage and any affected Riders thereto. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. In addition to the exclusions and limitations described in the Exclusions and Limitations section of the Certificate, we will not provide coverage for the following:

Conversion Therapy.

Effective on the date of issuance or renewal of this certificate on or after January 1, 2017, We do not cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

2. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which You may be entitled if your coverage under Your Certificate ends may not include any of the benefits of this Rider.

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doing business as

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By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR BREAST CANCER SCREENING

Issued by

EXCELLUS HEALTH PLAN, INC.

A Nonprofit Independent Licensee of the BlueCross BlueShield Association

This Rider changes certain benefits for breast cancer screening under Your Certificate of Coverage and any affected Riders thereto. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. The Mammography Screenings paragraph in the Outpatient Care and Professional Services sections of your Certificates are hereby deleted in their entirety and replaced with the following:

Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We Cover 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, We Cover mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating 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. Diagnostic mammograms are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

We also Cover additional screening and diagnostic imaging, including breast ultrasounds and MRIs, for the detection of breast cancer. Screening and diagnostic imaging for the detection of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

2. The Mammography Screenings subheading under the Preventive Care section of the Schedule of Benefits is being revised to read as follows: Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.
3. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which You may be entitled if your coverage under Your Certificate ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR INPATIENT SUBSTANCE USE DISORDER TREATMENT AT PARTICIPATING OASAS-CERTIFIED FACILITIES

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds certain substance use disorder treatment requirements under Your Certificate of Coverage and any affected Riders thereto. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. The last two sentences under the last paragraph of the Utilization Review section of your Certificates are deleted and replaced with the following:

For substance use disorder treatment, We will use evidence-based and peer reviewed clinical review tools designated by the New York State Office of Alcoholism and Substance Abuse Services ("OASAS") that are appropriate to the age of the patient. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website.

2. The Concurrent Reviews provision under the Utilization Review section of your Certificates is hereby amended to include the following:

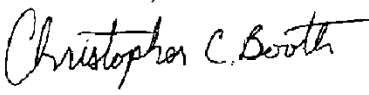
Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities. Coverage for inpatient substance use disorder treatment at a Participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within 48 hours of the admission. After the first 14 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

3. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which You may be entitled if your coverage under Your Certificate ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



RIDER TO REMOVE TRANSSEXUAL SURGERY AND RELATED SERVICES EXCLUSIONS AND CHANGE TO STATUTE OF LIMITATIONS

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes provisions in, or adds provisions to Your Certificate of Coverage and any affected Riders thereto. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. The Transsexual Surgery and Related Services paragraph in the Exclusions section of your Certificates is hereby deleted in its entirety.
2. The Excluded Services paragraph under the Infertility Services Treatment subsection in the Outpatient Care and Professional Services sections of Your Certificates is deleted and replaced with the following:

Excluded Services. We will not pay benefits for the following reproductive procedures or services:

- (1) In-Vitro Fertilization;
 - (2) Gamete Intra-Fallopian Transfer (GIFT);
 - (3) Zygote Intra-Fallopian Transfer (ZIFT);
 - (4) Reversal of elective sterilizations, including vasectomies and tubal ligations;
 - (5) Cloning;
 - (6) Sperm banking and donor fees associated with artificial insemination or other procedures;
 - (7) Other procedures or categories of procedures excluded by statute.
3. The Time to Sue provision under the General Provisions section of Your Certificate is amended to read as follows:
Time to Sue. No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

4. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which You may be entitled if your coverage under Your Certificate ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.

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165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



GOVERNMENT PROGRAMS EXCLUSION RIDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider clarifies the government programs exclusion under your Certificate of Coverage and any affected Riders thereto. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Government Programs.** The paragraph entitled "Government Programs" in the Exclusions Section of your Certificate is hereby deleted in its entirety and replaced with the following:

Government Programs. We 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, we 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 Subscriber is in "current employment status" (working actively and not retired) with the group contract holder; and
 - (2) The Subscriber's employer maintains or participates in an employer group health plan that is required by law to have this Certificate 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 Subscriber is in "current employment status" (working actively and not retired) with the group contract holder; and
 - (2) The Subscriber's employer maintains or participates in a large group health plan, as defined by law, that is required by law to have this Certificate 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. We will not reduce this Certificate's benefits, and we will provide benefits before Medicare pays, during the waiting period. We will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before we provide benefits under this Certificate.
2. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Certificate ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



This is your
THREE-TIER PRESCRIPTION DRUG CERTIFICATE OF COVERAGE

Issued by
EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Certificate of Coverage ("Certificate") explains the benefits available to you under a Group Contract between Excellus Health Plan, Inc. (hereinafter referred to as "we", "us", "our", or "the Plan") and the group contract holder listed in the Group Contract. This Certificate is not a contract between you and us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer

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SECTION ONE - INTRODUCTION AND DEFINITIONS

1. **Your Coverage Under This Certificate.** Your employer or organization (referred to as the "group contract holder") has purchased a group health insurance contract from us. Under that contract we will provide the benefits described in this Certificate to members of the group, that is, to employees of the employer or to members of the organization and their covered dependents. However, this Certificate is not a contract between you and us. You should keep this Certificate with your other important papers so that it is available for your future reference.
2. **Definitions.**
 - A. **Brand Name Drug.** A drug that is manufactured and marketed under a trademark or name by a specific manufacturer.
 - B. **Calendar Year.** The 12-month period beginning on January 1 and ending on December 31. However, if you were not covered under this Certificate for this entire period, Calendar Year means the period from the date you became covered until December 31.
 - C. **Copayment.** The amount charged to a Member by the Participating Pharmacy for the dispensing, including each refill, of a Prescription Drug, before we will make any payments under this Certificate.
 - D. **Effective Date.** The date your coverage under this Certificate begins. Coverage begins at 12:01 a.m. on the Effective Date.
 - E. **Generic Drug.** A drug that is chemically equivalent to a Brand Name Drug whose patent has expired, and that meets our criteria for designation as a Generic Drug.
 - F. **Medical Necessity.** See Section Three.
 - G. **Member.** Any Subscriber or eligible dependent who meets all applicable eligibility requirements, for whom the required premium payment has actually been received by us, and who is covered under this Certificate.
 - H. **Non-Participating Pharmacy.** Any pharmacy that dispenses Prescription Drugs and has not entered into a participation agreement with us. **We will not pay any benefits under this Certificate for Prescription Drugs you purchase at a Non-Participating Pharmacy.**
 - I. **Participating Pharmacy.** Any pharmacy that regularly dispenses Prescription Drugs and has entered into a participation agreement with us.
 - J. **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 us. The drug or medication must be prescribed by a provider authorized to prescribe, and approved by the FDA for the treatment of your specific diagnosis or condition. The drug must also be approved by us 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 us and our provider community, defining whether certain drugs will be covered under this Certificate. However, if there is a drug that has been approved for the treatment of one type of cancer, we 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).

Prescription Drugs shall include Medically Necessary enteral formulas for which an authorized provider has issued a written order. The written order must state that the enteral formula is clearly Medically Necessary and has been proven effective as a disease-specific method of treatment for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated. We 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 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 covered under your medical plan.

Prescription Drugs include drugs and devices, or their generic equivalents, approved by the FDA for treatment of osteoporosis. We will apply our standards and guidelines that are consistent with the criteria of the federal Medicare program or the National Institutes of Health ("NIH") to determine appropriate coverage for treatment of osteoporosis under this Certificate. We will provide coverage for drugs and devices covered under Medicare or consistent with the NIH criteria. When consistent with the Medicare or NIH criteria, coverage, at a minimum, will be provided for those Members:

- (1) Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- (2) With symptoms or conditions indicative of the presence, or a significant risk, of osteoporosis; or
- (3) On a prescribed drug regimen posing a significant risk of osteoporosis; or
- (4) With lifestyle factors to the degree of posing a significant risk of osteoporosis; or
- (5) With such age, gender and/or physiological characteristics that pose a significant risk of osteoporosis.

K. **Subscriber.** The member of the group to whom this Certificate is issued.

L. **"We", "Us", "Our" or "The Plan" and "You", "Your" and "Yours".** Throughout this Certificate, Excellus Health Plan, Inc. will be referred to as "we", "us", "our" or "the Plan". The word "you", "your" or "yours" refers to you, the Subscriber. If other than individual coverage applies, then in most cases the word "you" also includes any family members who are covered under this Certificate.

M. **Tier One Drug.** A Generic Drug that we designate as a Tier One Drug.

N. **Tier Two Drug.** A Prescription Drug that is included on our Tier Two Drug list. Tier Two Drugs are selected for their effectiveness, utilization and cost.

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

Our list of Tier One, Tier Two and Tier Three Drugs as defined above is always under review and subject to update. A copy can be obtained from our office upon request.

SECTION TWO - WHO IS COVERED

1. **Who Is Covered Under This Certificate.** Subject to the permissible eligibility rules of the group contract holder, you, the Subscriber to whom this Certificate is issued, are covered under this Certificate. If you selected other than individual coverage, the following members of your family may also be covered:

- A. Your spouse, unless you are divorced or your marriage has been annulled.
- B. Your unmarried children who are under 19 years of age and who are chiefly dependent on you for support.
- C. Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age at which the child's coverage under this Certificate would otherwise have terminated. The child's disability must be certified by a physician. You must file an application in the form we approve to request that the child be included in your family coverage. We have the right to check whether a child is and continues to qualify under this paragraph. (See Section Eight for when coverage terminates.)

We have the right to request, and have furnished to us, such proof as may be needed to determine eligibility status of a prospective Subscriber and all prospective dependents as they pertain to eligibility for coverage under this Certificate.

2. **Other Children Covered Under This Certificate.**

In addition to your natural children, the following other children may also be covered under this Certificate if the child meets the above eligibility requirements for children covered under this Certificate:

- A. A legally adopted child;

- B. A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order;
- C. A stepchild who is chiefly dependent upon you for support; and
- D. A child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption becoming final.

We have the right to request, and have furnished to us, such proof as may be needed to determine whether a child qualifies as a dependent for purposes of coverage under this Certificate.

3. **Newborn Child.** If you have a type of coverage that would cover a newborn, your newborn child will be covered at birth, provided you notify us within 30 days of the birth by completing the enrollment form to add the child to your coverage. If you are changing your type of coverage (for example from individual to family coverage) in order to cover the newborn child, you must complete the enrollment form to extend your coverage to include your child within 30 days of the birth. If you do not complete the form within 30 days of the birth, coverage of the child will not become effective until the next premium due date after we receive the application. If a child of yours who is covered under this Certificate gives birth, your newborn grandchild will not be covered (unless any of the criteria of Paragraph 2 above apply).
4. **Adopted Newborns.** If you have a type of coverage that will cover a newborn, or switch to a type of coverage that will cover a newborn, in accordance with Paragraph 3 above, we will cover a proposed adoptive newborn from the moment of birth if you (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the Hospital after birth and you file a petition within 30 days of the infant's birth pursuant to §115-C of the New York State Domestic Relations Law or a comparable provision when the child is adopted in another state. However, we will not provide coverage for the initial Hospital stay of an adopted newborn if one of the child's natural parents has coverage available to cover the newborn's initial Hospital stay. We will also not provide coverage for the newborn if a notice of revocation of the adoption has been filed or one of the natural parents revokes consent to the adoption. If we provide coverage of an adopted newborn and notice of the revocation of the adoption is filed or one of the natural parents revokes their consent, we will be entitled to recover any sums paid by us for care of the adopted newborn.
5. **Types Of Coverage Other Than Individual Coverage.** We offer different types of coverage in addition to individual coverage:
 - A. Family Coverage - If family coverage applies, then you, the Subscriber, and your spouse and your children as described above are covered.
 - B. Spousal Coverage - If spousal coverage applies, then only you, the Subscriber, and your spouse as described above are covered.
 - C. Child Coverage - If child coverage applies, then you, the Subscriber, and your child or children as described above are covered.
 - D. Two-Person Coverage - If two-person coverage applies, then you, the Subscriber, and your spouse or one child as described above are covered. You may only select two-person coverage if your family unit consists of two people.

The names of all persons covered under this Certificate must have been specified on the enrollment form for this Certificate or provided to us as described in Paragraph 8 below. No one else can be substituted for those persons. We have administrative rules to determine which types of coverage are available to members of your group. You are only entitled to the types of coverage for which we receive premium and that our records indicate is applicable. You may call us if you have any questions about which type of coverage applies to you.

6. **When Coverage Begins.** Coverage under this Certificate will begin as follows:
 - A. If you, the Subscriber, 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 Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible, you must wait until the group's next open enrollment period, except as provided in Paragraph 7 below. When you enroll during the next open enrollment period, coverage then begins at 12:01 a.m. on the date to which the open enrollment period applies.

- C. If you, the Subscriber, marry while covered, and we receive notice of such marriage within 30 days thereafter, coverage for your spouse starts at 12:01 a.m. on the date of your marriage. If we do not receive notice of the marriage within the 30-day period, your spouse must wait until the next open enrollment period for coverage. When your spouse is enrolled during the next open enrollment period, coverage for your spouse will start at 12:01 a.m. on the date to which the open enrollment period applies.
7. **When You Reject Initial Enrollment Or Elect Not To Enroll During Open Enrollment, But Do Not Need To Wait Until The Group's Next Open Enrollment Period To Enroll For Coverage.** If you, the Subscriber, reject initial enrollment under this Certificate, or elect not to enroll during a subsequent open enrollment, you may enroll for coverage if the following conditions are met:
- A. You or your spouse 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 spouse lost eligibility for one or more of the following reasons:
- (1) Termination of employment;
 - (2) Termination of the other plan or contract;
 - (3) Death of the spouse;
 - (4) Legal separation, divorce or annulment;
 - (5) Reduction in the number of hours worked;
 - (6) The employer or other group ceased its contribution toward the premium for the other plan or contract;
 - (7) The coverage was under an HMO, and you no longer live, work or reside in the HMO service area;
 - (8) Cessation of dependent child status;
 - (9) Benefits are no longer offered to similarly situated individuals (e.g., part-time employees);
 - (10) The benefit maximum under the plan or contract has been reached; or
- C. You acquire a dependent due to birth, adoption, guardianship, placement for adoption or marriage, in which case you, the Subscriber, may enroll for individual coverage or for a type of coverage available to your group that will cover you and your eligible dependents.
- D. You apply for coverage under this Certificate within 30 days after: termination for one of the reasons set forth in Subparagraph B above; or acquisition of a dependent as set forth in Subparagraph C above.
- If you enroll for coverage pursuant to Subparagraphs A and B above, your coverage will begin at 12:01 a.m. on the date of the loss of coverage. 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.
8. **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 (other than a newborn child added under Paragraph 3 or 4 above), you must complete and return to us a form for this purpose and any requested documentation. The addition of a spouse or child will be effective as of the date of marriage, adoption or other event making the child eligible for coverage under Paragraph 2, if you return to us a completed application and requested documents within 30 days of the wedding, adoption or other event, and the applicable premium is paid. If you do not return a completed form and documentation within 30 days, your spouse or child will be added to your coverage after the next open enrollment period, so long as the applicable premium is paid.
- B. **When Coverage of a Spouse or Child Terminates.** If you have other than individual coverage, you should notify us of any event that affects your coverage, such as: your divorce, the death of your spouse or Medicare eligibility; or a child marrying, leaving school, reaching the age at which coverage

terminates or otherwise experiencing an event that would normally result in termination of dependent coverage. We will provide you with a form for that purpose. If such change results in you seeking a different type of coverage at a lower premium (such as a switch to individual coverage), the form and requested documentation must be returned within 30 days of the event in order for the change in premium to be effective on the date of the event. If you do not return a completed form and any requested documentation within 30 days of the event, the change in premium will be effective as of the next premium due date after they are received. Nothing in this Subparagraph B is designed to affect the provisions of Section Eight governing terminations of coverage. This Subparagraph B only involves the effective date of changes in premiums due to terminations of coverage under Section Eight.

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

SECTION THREE - MEDICAL NECESSITY AND PRIOR APPROVAL

1. **Care Must Be Medically Necessary.** We will provide coverage under this Certificate for the covered benefits described in this Certificate as long as the drug or device (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 we have to provide coverage for it.

We will decide whether a Service was Medically Necessary. We will base our decision in part on a review of your medical records. We will also evaluate medical opinions we receive. 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, we will also consider:

- A. Reports in peer reviewed medical literature;
- B. Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- C. Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care or treatment;
- D. The opinion of health professionals in the generally recognized health specialty involved;
- E. The opinion of the attending physicians and other medical providers, which have credence but do not overrule contrary opinions; and
- F. Any other relevant information brought to our attention.

Services will be deemed Medically Necessary only if:

- A. They are clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease;
- B. They are required for the direct care and treatment or management of that condition;
- C. If not provided, your condition would be adversely affected;
- D. They are provided in accordance with generally-accepted standards of medical practice;
- E. They are not primarily for the convenience of you, your family, the physician or another prescribing provider;
- F. They are not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease.

2. **Service Must Be Approved Standard Treatment.** Except as otherwise required by law, no Service rendered to you will be considered Medically Necessary unless we determine that the Service is consistent with the diagnosis and treatment of your medical condition; generally accepted by the medical profession

as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative. Please see Section Nine, paragraph 28 for your right to an external appeal of our determination that a Service is not Medically Necessary.

3. **Prior Authorization.** We will periodically identify certain Prescription Drugs that, for reasons such as cost and possible use for purposes that are not Medically Necessary or appropriate, will only be filled with prior authorization from us. The Prescription Drugs that require prior authorization are included on the form entitled "Prescription Drugs Requiring Prior Authorization".
 - A. **Prior Authorization Procedure.** If you seek coverage for a Prescription Drug that requires prior authorization, you initiate the prior authorization procedure by calling the number on your ID card; and your provider must submit a statement of Medical Necessity to us. After receiving a request for prior authorization, we will review the statement of Medical Necessity and determine if benefits are available. We will notify you and your physician or other prescribing provider of our decision by telephone and in writing within three business days of receipt of all necessary information. If the Prescription Drug involves continued or extended health care services, or additional services for a course of continued treatment, we will notify you and your provider within one business day of receipt of all necessary information.
 - B. **Your Right To Appeal.** If you or your provider disagrees with our decision, you may appeal by following the procedures set forth in Section Nine, paragraph 27. Any written appeals must be made to: 165 Court Street, Rochester, NY 14647.
 - C. **Failure To Seek Authorization.** When you fail to seek our prior authorization of a Prescription Drug that requires such authorization and the drug is dispensed, you must pay the Participating Pharmacy for the drug. If you then submit a claim to us, we will pay only 50% of the amount we would otherwise have paid for the Prescription Drug. We will only pay this amount if we determine the Prescription Drug was Medically Necessary, even though you did not seek our prior authorization. If we determine that the Prescription Drug was not Medically Necessary, we will not make any payment for the drug; and you will be responsible for the entire charge.

SECTION FOUR - PRESCRIPTION DRUG BENEFITS

1. **Drugs From A Participating Retail Or Mail Service Pharmacy.**
 - A. If you have a prescription filled with a Tier One Drug, you must pay the pharmacy either a \$5 Copayment or the cost of the Tier One Drug, whichever is less, for each separate prescription or refill for that Tier One Drug. The pharmacy will be paid directly by us for the remainder of the cost of the prescription or refill. The Copayment does not apply to covered dependents under age 19.
 - B. If you have a prescription filled with a Tier Two Drug, you must pay the pharmacy either a \$15 Copayment or the cost of the Tier Two Drug, whichever is less, for each separate prescription or refill for that Tier Two Drug. The pharmacy will be paid directly by us for the remainder of the cost of the prescription or refill.
 - C. If you have a prescription filled with a Tier Three Drug, you must pay the pharmacy either a \$30 Copayment or the cost of the Tier Three Drug, whichever is less, for each separate prescription or refill for that Tier Three Drug. The pharmacy will be paid directly by us for the remainder of the cost of the prescription or refill.
 - D. If you have a prescription filled with a Tier Two or Tier Three Drug and there is a therapeutic equivalent Generic Drug available for that Tier Two or Tier Three Drug, we have special payment rules.

Our payment will be based on our therapeutic equivalent Generic Drug fee schedule allowance or the actual cost of the Generic Drug, whichever is less. You will be responsible for the Tier One Drug Copayment, if any, set forth in Subparagraph A above and the difference in cost between our payment and the actual cost of the Tier Two or Tier Three Drug.

For example, assume you have a prescription for a Tier Three Drug that costs \$100, and the therapeutic equivalent Generic Drug has a fee schedule amount of \$25. We will pay the \$25, less the applicable Copayment amount. You must pay the Tier One Drug Copayment plus the \$75 balance remaining on the \$100 charge.

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

Mandated Benefits. The benefits in this section include coverage required by New York law. Please see the definition of Prescription Drugs set forth in Section One, subparagraph 2. J. for a description of our coverage for: off-label cancer treatment drugs that meet the requirements of Section 4303 (q) of the Insurance Law; enteral formulas, modified solid food products; drugs to treat infertility (unless excluded under Section Six, paragraph 22 below); and drugs and devices for treatment of osteoporosis.

2. **Drugs From A Non-Participating Pharmacy. We will not pay for any benefits under this Certificate for drugs that you purchase at a Non-Participating Pharmacy.**

SECTION FIVE - LIMITATIONS

1. We will pay for no more than a 30-day supply of a drug purchased at a Participating retail Pharmacy; and you are responsible for one Copayment for each 30-day supply. Benefits will be provided for drugs dispensed by a Participating mail service Pharmacy in a quantity of up to a 90-day supply; and you are responsible for one Copayment for each 30-day supply up to a maximum of two Copayments for a 90-day supply. For example, a 90-day supply of a Tier One Drug requires two \$5 Copayments, or \$10. The first fill of a prescription is limited to a maximum of a 30-day supply.
2. We reserve the right to limit quantities, day supply, early refill access and/or duration of therapy for certain medications based on acceptable medical standards and/or FDA recommended guidelines.
3. Benefits will be provided for drug refills. However, no benefit will be provided for a refill obtained before the date that you should have exhausted most of your current supply. Benefits for refills will not be provided beyond one year from the original prescription date.
4. 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.
5. A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.
6. Various specific and/or generalized "use management" protocols will be used from time-to-time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide our Members with a quality-focused drug benefit. In the event a use management protocol is implemented, you will be notified in advance.
7. This Certificate is not intended to duplicate the benefits provided under your medical coverage. Examples of prescription coverage provided under your medical coverage and therefore not covered under this Certificate, include, but are not limited to: injectable drugs (other than self-administered injectable drugs as determined to be Medically Necessary); home infusion therapy; and diabetic insulin and supplies.

SECTION SIX - EXCLUSIONS

In addition to the exclusions and limitations described in other sections of this Certificate, we will not provide coverage for the following:

1. **Administration Or Injection.** We will not provide coverage for administration or injection of any drugs.
2. **Contraceptive Drugs.** We will not provide coverage for any contraceptive drugs unless they are prescribed for a medical purpose unrelated to contraception.
3. **Cosmetic Services.** We will not provide coverage for drugs that are prescribed or dispensed for cosmetic purposes and are not Medically Necessary. Examples of the kinds of drugs that we often determine to be not Medically Necessary include those prescribed or dispensed for hair growth or removing wrinkles.
4. **Court-Ordered Services.** We 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 Certificate in the absence of a court order;
 - B. Our 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 Certificate.

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

5. **Criminal Behavior.** We will not provide coverage for any service or care related to the treatment of an illness, accident or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred.
6. **Dental Care.** We will not provide coverage for any Prescription Drugs provided in connection with treatment of the teeth, gums, or structures supporting the teeth; or any form of dental surgery; regardless of the reasons(s) that the service or care is necessary. For example, we will not provide coverage for treatments for gum disease, therapy or other treatments related to dental TMJ disorder or dental oral surgery. We 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. In addition, we will provide the benefits set forth in this Certificate for service and care for treatment of sound natural teeth provided within 12 months of an accidental injury. We do not consider an injury to a tooth caused by chewing or biting to be an accidental injury. We will also provide coverage for the services set forth in this Certificate that we determine are Medically Necessary for treatment of a congenital anomaly or disease that was evident and observable at birth and caused by a medical condition that was present at birth. We will also provide coverage for the services set forth in this Certificate that we determine are Medically Necessary for treatment of cleft palate and ectodermal dysplasia.
7. **Devices.** We will not provide coverage for devices of any type, even though a prescription may be required, except for devices for treatment of osteoporosis as provided in Section One, subparagraph 2. J. of this Certificate. This includes contraceptive devices, therapeutic devices, artificial appliances, hypodermic needles or similar devices.
8. **Diabetic Equipment And Supplies.** Your benefit for diabetic supplies and equipment is not provided under this Certificate. The following diabetic supplies and equipment are not covered under this Certificate: blood glucose monitors; test strips; injection aids; syringes; insulin pumps; and insulin infusion devices. We will also not provide benefits for insulin and oral hypoglycemics under this Certificate when they are covered under your medical plan.
9. **Experimental And Investigational Services.** Unless otherwise required by law, we will not provide coverage for any service or care that consists of a drug, biological product, or medical device (collectively, Service"), if we determine that the Service is experimental or investigational. See Section Nine, paragraph 27 for your right to an external appeal of our determination that a Service is experimental or investigational.

"Experimental or investigational" means that we determine 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, we may, in our 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 Certificate 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.

- 10. **Free Care.** We 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 Certificate. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your spouse, brother, sister, mother, father, son or daughter; or the spouse of any of them; we will presume that the service or care would have been furnished without charge. You must prove to us that a service or care would not have been furnished without charge.
- 11. **Government Programs.** Except as provided below when you are covered under Medicare, we will not provide coverage for any service or care for which benefits are payable under any federal, state, or local government program, except when required by state or federal law. When you are covered under Medicare, and Medicare is primary according to federal law, Medicare benefits and the benefits under this Certificate will be coordinated as set forth in Section Seven.

According to federal law, Medicare is not primary 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 Subscriber is in "current employment status" (working actively and not retired) with the group contract holder; and
 - (2) The Subscriber's employer maintains or participates in an employer group health plan that is required by law to have this Certificate 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 Subscriber is in "current employment status" (working actively and not retired) with the group contract holder; and
 - (2) The Subscriber's employer maintains or participates in a large group health plan, as defined by law, that is required by law to have this Certificate 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. During the waiting period, benefits under this Certificate are primary. We will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before we provide benefits under this Certificate.
12. **Lost Or Stolen.** We will not provide coverage for Prescription Drugs to replace those that may have been lost or stolen.
 13. **Military Service-Connected Conditions.** We will not provide coverage for any service or care related to any military service-connected disability or condition, if the Veterans Administration (VA) has the responsibility to provide the service or care.
 14. **No-Fault Automobile Insurance.** We 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. We will provide benefits for services covered under this Certificate 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, we will provide coverage for the services covered under this Certificate, up to the amount of the deductible. We will not provide benefits even if you bring a lawsuit against the person who caused your injury and even if you receive money from that lawsuit and you have repaid the medical expenses you received payment for under the mandatory automobile no-fault coverage.
 15. **Non-Covered Service.** We will not provide coverage for any service or care that is not specifically described in this Certificate as a covered service; or that is related to service or care not covered under this Certificate; even when your provider considers the service or care to be Medically Necessary and appropriate.
 16. **Non-Covered Place Of Service.** We will not provide coverage for drugs given or administered in a physician's office or in an inpatient or outpatient facility, including drugs dispensed to a Member while a patient in a hospital, nursing home, other institution, or a home care patient, except in those cases where the basis of payment by or on behalf of the Member to the hospital, nursing home, home health agency or home care services agency, or other institution, does not include services for drugs.
 17. **Non-Prescription Drugs.** We will not provide coverage for drugs that do not by law require a prescription, except as otherwise provided in this Certificate.
 18. **Not Normal Medical Practice.** We will not provide coverage for drugs prescribed or dispensed in a manner contrary to normal medical practice.
 19. **Nutritional Therapy.** We will not provide coverage for any service or care related to nutritional therapy, unless we determine that it is Medically Necessary. We will not provide coverage for commercial weight loss programs or other programs with dietary supplements.
 20. **Over-The-Counter.** We also will not provide coverage for Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name as their prescription counterparts.
 21. **Prohibited Referral.** We will not provide coverage for drugs or other pharmacy services provided to you pursuant to a referral prohibited by Section 238-a of the New York Public Health Law. (Generally, Section 238-a prohibits providers from making referrals for pharmacy or other services to a provider, pharmacy or facility in which the referring provider or an immediate family member has a financial interest or relationship.)
 22. **Reproductive Procedures.** We will not provide coverage for fertility drugs relating to the following infertility treatment services: in vitro fertilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); reversal of elective sterilizations, including vasectomies and tubal ligations; sex change procedures; cloning; and other procedures or categories of procedures excluded by statute.
 23. **Self-Help Diagnosis, Training And Treatment.** We 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 Starting Before Coverage Begins.** If you are receiving care on the Effective Date of your coverage under this Certificate, we will not provide benefits for any service or care you receive:
 - A. Prior to the Effective Date of your coverage under this Certificate; or
 - B. On or after the Effective Date of your coverage under this Certificate, if that service or care is covered under any other health benefits contract, program, or plan.
25. **Smoking Cessation Programs.** We will not provide coverage for smoking cessation programs.
26. **Unit Packaging.** We will not provide coverage for drugs dispensed in unit-dose packaging when bulk packaging is available.
27. **Unlicensed Provider.** We 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. **Vitamins.** We will not provide coverage for vitamins, or any herbal product, except those that require a prescription by law.
29. **Weight Loss Services.** We will not provide coverage for any service or care in connection with weight loss programs. We will also not provide benefits for any covered service or care set forth in this Certificate when rendered in connection with weight reduction or dietary control, unless Medically Necessary.
30. **Workers' Compensation.** We will not provide coverage for drugs for which benefits are provided under a workers' compensation law or similar legislation.

SECTION SEVEN - COORDINATION OF BENEFITS

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

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

the other plan does not have the rule described immediately above, but instead has a rule based on gender of a parent and, as a result, the plans do not agree on which shall be primary, then the father's plan will be primary.

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

- (1) If the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.
 - (2) If no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:
 - (a) First, the plan of the parent with custody of the child;
 - (b) Then, the plan of the spouse of the parent with custody of the child;
 - (c) Finally, the plan of the parent not having custody of the child.
- D. If you are covered under one of the plans as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, and you are covered as a laid-off or retired employee or a laid-off or retired employee's dependent under the other plan, the plan covering you as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.
- E. If none of the above rules determine which plan shall be primary, then the plan that has covered you for the longest time will be primary.
3. **Payment Of The Benefit When This Plan Is Secondary.** When this plan is secondary, the benefits of this plan will be reduced so that the total benefits payable under the other plan and this plan do not exceed your expenses for an item of service. However, we will not pay more than we would have paid if we were primary.

We count 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. We will request information from that plan so we can process your claims. If the primary plan does not respond within 30 days, we will assume its benefits are the same as ours. If the primary plan sends the information after 30 days, we will adjust our payment, if necessary.

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

4. **Right To Receive And Release Necessary Information.** We have the right to release or obtain information that we believe necessary to carry out the purpose of this section. We 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. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information that we request. If you do not furnish the information to us, we have the right to deny payments.
5. **Payments To Others.** We may repay to any other person, insurance company or organization the amount which it paid for your covered services and which we decide we should have paid. These payments are the same as benefits paid.
6. **Our Right To Recover Overpayment.** In some cases we may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other plan. You must sign any document that we deem necessary to help us recover any overpayment.

SECTION EIGHT - TERMINATION OF YOUR COVERAGE

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

1. **Termination Of The Group Contract.** This Certificate is provided under the terms of the Group Contract between us and the group contract holder. The Group Contract is effective for one year and will automatically be renewed each year unless it is terminated as set forth below.
 - A. The group contract holder terminates the Group Contract pursuant to its terms. In this case, your coverage will terminate on the date the group contract holder terminates;
 - B. We do not receive premium payment from the group contract holder as of the date the premium was due. In this case, your coverage will end on the date to which the premium has been paid;
 - C. The group contract holder has committed fraud or made an intentional misrepresentation of material fact under the terms of the Group Contract. In this case, your coverage will terminate 30 days from the date we provide notice to you;
 - D. The group contract holder no longer qualifies as a group. We have certain administrative rules that describe our requirements for group contract holders. Our rules are consistent with New York State law and regulations governing health insurance. If you have a question about the rules that apply to your group contract holder, you may contact us and we will explain them to you.

When your group contract holder no longer meets our requirements, we will notify you. Your coverage will terminate 30 days from the date we provide notice to you;
 - E. The group contract holder fails to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under section 4235 of the Insurance Law. In this case, your coverage will terminate 30 days from the date we provide notice to you;
 - F. The group contract holder no longer has any enrollee living, residing or working in New York State. In this case, your coverage will terminate 30 days from the date we provide notice to you;
 - G. Any reason approved by the New York State Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act. In this case, your coverage will terminate 30 days from the date we provide notice to you;
 - H. If we terminate the entire class of contracts to which this Certificate belongs. In this case, your coverage will terminate 90 days from the date we provide notice to you; or
 - I. If we withdraw from the applicable market through which you obtained coverage under this Certificate, and we cease offering any products in that market. In this case, your coverage will terminate six months from the date we provide notice to you.
2. **Termination Of Your Coverage Under This Certificate.** In the following instances, the Group Contract will continue in force, but your coverage under this Certificate will be terminated:
 - A. You choose to terminate your coverage. You must give the group contract holder 30 days' written notice. Your coverage will terminate on the date to which your premium is paid;
 - B. You are no longer a member of the group. Your coverage will terminate on the date to which your premium is paid if you are no longer a member of the group;
 - C. You committed fraud in applying for coverage or in filing a claim under this Certificate. Your coverage will terminate 30 days from the date we provide notice to you;
 - D. Any reason approved by the Superintendent of Insurance. In this case, your coverage will terminate 30 days from the date we provide notice to you. A copy of the reason for the termination of your coverage will be provided to you upon request;
 - E. On your death or the death of the Subscriber. Your coverage under this Certificate will automatically terminate on the date after your death or the death of the Subscriber;
 - F. Termination of the Subscriber's marriage. If the Subscriber becomes divorced, or the Subscriber's marriage is annulled, coverage of the Subscriber's spouse under this Certificate will automatically terminate on the date of the divorce or annulment; or
 - G. Termination of coverage of a child. Coverage of a Subscriber's child under this Certificate will terminate on the date the child no longer qualifies as a dependent under Section Two of this Certificate or, if later, the next premium due date after we receive notice of termination.

3. **Temporary Continuation Of Coverage.** Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If you are not entitled to temporary continuation of coverage under COBRA, you may be entitled to temporary coverage under the New York Insurance Law as described below. Call or write your employer or us to find out if you are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

Under New York State law, if you lose coverage because of termination of employment or membership in the class or classes eligible for coverage, you may continue coverage for yourself and your eligible dependents subject to the following conditions:

- A. You are not entitled to Medicare; and you are not covered under or eligible for other group coverage that does not exclude or limit coverage for pre-existing conditions;
- B. You must request continued coverage within 60 days after the later of: the date of termination; or the date you are given notice of continuation by the group. If you wish continuation under Subparagraph D. (4) below, you must notify the group within 60 days after a determination that you were disabled under the Social Security Act at the time of termination of employment or membership or within the first sixty days of continuation coverage;
- C. You must pay the premium (not more frequently than monthly) when due. The first payment is due within 60 days after the later of the date coverage would otherwise terminate or the date you are given notice of continuation by the group. The premium cannot exceed 102% of the group's premium rate;
- D. Coverage will terminate at the earliest of the following:
 - (1) The date 18 months after your coverage would have terminated because of termination of employment or membership;
 - (2) The date to which premiums are paid if you fail to make a timely payment;
 - (3) If you are an eligible dependent, the date 36 months after coverage would have terminated due to: death of the employee or member; divorce or legal separation, the employee or member's eligibility for Medicare; failure to qualify under the definition of "children";
 - (4) The date 29 months after coverage would have otherwise terminated because of termination of employment or membership if the employee or member is determined to have been disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first sixty days of continuation coverage. However, if the employee or member is no longer disabled, coverage will terminate at the later of the date in Subparagraph D. (1) above; or the month that begins more than 31 days after determination that the employee or member is no longer disabled; or
 - (5) The date the group no longer provides coverage to any of its employees or members.

SECTION NINE - GENERAL PROVISIONS

- 1. **No Assignment.** You cannot assign any benefits or monies due under the Group Contract or this Certificate 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 Certificate or your right to collect money from us for those services.
- 2. **Notice.** Any notice that we give to you under this Certificate will be mailed to your address as it appears on our records or to the address of the group contract holder. If you have to give us any notice, it should be mailed to: 165 Court Street, Rochester, NY 14647.
- 3. **Your Medical Records.** As a condition precedent to the approval of claims hereunder, each Member authorizes and directs any Participating Pharmacy that furnishes benefits hereunder to make available to us information relating to all prescription orders, copies thereof and other records as needed by us for purposes of administering this Certificate. In every case we will hold such information and records as confidential.

In order to provide your coverage under this Certificate, it may be necessary for us to obtain information relating to all prescription orders, copies thereof and other records as needed by us for the purpose of administering this coverage. Our 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 Certificate, you automatically authorize and direct any Participating Pharmacy that furnishes benefits hereunder to make records available to us and give us permission to obtain and use those records for those purposes.

We agree to maintain that information in accordance with state and federal confidentiality requirements. However, you automatically give us permission to share that information with the New York State Department of Health, quality oversight organizations and third parties with which we contract to assist us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

4. **Who Receives Payment Under This Certificate.** Payments under this Certificate for service provided by a Participating Pharmacy will be made directly by us to the pharmacy.
5. **Time To File Claims.** Claims for services under this Certificate must be submitted to us for payment within 12 months after you receive the services for which payment is being requested.
6. **Time To Sue.** No action at law or in equity may be maintained against us prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Certificate. You must start any lawsuit against us under this Certificate within twenty-four months from the date you received the service for which you want us to pay.
7. **Venue For Legal Action.** If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against us 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 we bring against you.
8. **Choice Of Law.** This Certificate shall be governed by the laws of the State of New York.
9. **Recovery Of Overpayments.** On occasion a payment will be made when you are not covered, for a service that is not covered, or which is more than is proper. When this happens we will explain the problem to you and you must return the amount of the overpayment to us within 60 days after receiving notification from us.
10. **Right To Offset.** If we make a claim payment to you or on your behalf in error or you owe us any money, you must repay the amount you owed to us. If we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we owe you.
11. **Continuation Of Benefit Limitations.** Some of the benefits under this Certificate are limited to a specific days' supply or annual maximum. 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 dependent to Subscriber, all benefits previously utilized when you were a dependent will be applied toward your new status as a Subscriber.
12. **Subrogation.** In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and we pay benefits as a result of that injury or illness, we will be subrogated and succeed to the right of recovery against the party responsible for your illness or injury to the extent of the benefits we have paid.

Duty to Cooperate with Us - Possible Penalties for Failure to Cooperate. Under certain circumstances, we are also entitled to be reimbursed for the benefits we have paid from a settlement or a judgment you receive from the party responsible for your illness or injury. This and other penalties which apply under certain circumstances are noted below. Those circumstances are:

- A. The settlement or judgment you receive from the party responsible for your illness or injury specifically identifies or allocates monetary sums directly attributable to expenses for which we have paid benefits; or

- B. You fail to cooperate with us in proceeding against the party responsible for your illness or injury to recover the benefits we have paid. We will pay all expenses associated with a legal action instituted on our initiative.

The penalty for failing to cooperate under Subparagraph B above is that you will be responsible to repay to us the amount of the benefits we have paid. We agree to invoke Subparagraph B only when your illness or injury caused by a third party results in our expenditure on your behalf of an amount exceeding \$500 under this coverage. In any of these provisions where we must give our prior written consent, we agree not to unreasonably withhold our prior consent and we agree to waive all penalties under these provisions if we do not give or withhold our prior consent within 30 days from the date you or your legal representative seeks prior consent in writing from us.

13. **Who May Change This Certificate.** The Certificate may not be modified; amended; or changed, except in writing, and signed by our Chief Operating Officer (COO) or a person designated by the COO. No employee; agent; or other person is authorized to interpret; amend; modify; or otherwise change the Certificate 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 or person designated by the COO.
14. **Changes In This Certificate.** We may unilaterally change this Certificate upon the group's renewal, if we give the group contract holder 44 days' prior notice.
15. **Renewal Date.** The renewal date for the Certificate is January 1 of each year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by us or the group contract holder as permitted by the Certificate or by you upon 30 days' prior written notice to the group contract holder.
16. **Agreements Between The Plan And Participating Pharmacies.** Any agreement between us and Participating Pharmacies may only be terminated by us or the pharmacies. This Certificate does not require any pharmacy to accept a Member as a customer. We do not guarantee a Member's access to any Participating Pharmacy.
17. **Material Accessibility.** We will give the group contract holder, and the group contract holder will give Members, identification cards, Certificates, Riders and other necessary materials.
18. **Refund.** We will give any refund of premiums, if due, to the group contract holder.
19. **Notice Of Claim.** Claims for services under this Certificate must include all information designated by us 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 will not be accepted and must be resubmitted with all necessary information.
20. **Identification Cards.** Identification cards are issued by us for identification only. Possession of any identification card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits the Member's premiums must be paid in full at the time that the services are sought to be received. Coverage under this Certificate may be terminated by us if the Member allows another person to wrongfully use the identification cards.
21. **Right To Develop Guidelines And Administrative Rules.** We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Certificate. Examples of the use of the standards are: to determine whether care was Medically Necessary. Those standards will not be contrary to the descriptions in this Certificate. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Certificate.
22. **Furnishing Information And Audit.** The group contract holder and all persons covered under this Certificate will promptly furnish us with all information and records that we may require from time to time to perform our obligations under this Certificate. You must provide us with information over the telephone for reasons like the following: to allow us to determine the level of care you need; so that we may certify care authorized by your physician; or to make decisions regarding the Medical Necessity of your care. The group contract holder will, upon reasonable notice, make available to us, and we may audit and make copies of, any and all records relating to group enrollment at the group contract holder's New York office.

23. **Enrollment; ERISA.** The group contract holder further 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 Certificate, and any other information required to confirm their eligibility for coverage. The group contract holder will provide us with the enrollment form including your name, address, age, and social security number and to advise us in writing when you are to be added to or subtracted from our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date the group's contract with us. If the group contract holder fails to so advise us, the group contract holder will be responsible for the cost of any claims paid by us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 60 days.

The group contract holder 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 contract holder, or a third party appointed by the group contract holder. We are not the ERISA plan administrator.

24. **Reports And Records.** We are entitled to receive from any provider of services to Members, information reasonably necessary to administer this Certificate subject to all applicable confidentiality requirements as defined in the General Provisions Section of this Certificate. By accepting coverage under this Certificate, the Member, for himself or herself, and for all covered dependents 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 us, or to a medical, dental or mental health professional or pharmacist that we may engage to assist us 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 us, or to a medical, dental or mental health professional or pharmacist that we may engage to assist us in reviewing a treatment or claim; and
- C. Permit copying of the Member's records by us.

25. **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 the obligations created under this agreement.

26. **Grievance Procedures.** We maintain procedures to resolve Member grievances. These procedures make sure that we resolve your questions, concerns, and complaints in a timely, fair manner.

- A. **Filing a Grievance.** Our Grievance Procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by us. To initiate a grievance, just contact us. We keep all requests and discussions confidential and we'll take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry. We maintain a file on each grievance.

You can either contact our Customer Service Department by phone, in person or in writing to file a grievance. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

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

We will decide your grievance and notify you of our determination in writing within 30 calendar days of receipt of your grievance request.

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

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

B. **Notice of Determination.** The notice of determination of your grievance will include detailed reasons and, if a clinical matter is involved, the clinical rationale, and further appeal rights, if any. We will send notices to you or your representative and to your health care provider.

If you remain dissatisfied with our grievance determination or at any other time you are dissatisfied, you may:

Call the New York State Department of Insurance at 1-800-342-3736 or write them at:

New York State Department of Insurance
Consumer Services Bureau
One Commerce Plaza
Albany, NY 12257
www.ins.state.ny.us

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

We have developed Utilization Review policies to assist us in administering the Utilization Review program. These policies describe the process and procedures of Utilization Review activities. Reviews are conducted by registered nurses and our Medical Directors. All determinations that services are not Medically Necessary will be made by licensed physicians. We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not or were not Medically Necessary. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review at our office. For more information, you can contact us. Our failure to make a Utilization Review determination within the applicable time frames set forth below shall be deemed an adverse determination subject to an internal appeal.

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

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

With respect to urgent prospective claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 72 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

B. **Retrospective Reviews.** At our option, a nurse will review retrospectively the Medical Necessity of claims that are subject to Utilization Review. If the nurse determines that care you received was Medically Necessary, the nurse will authorize the benefits. If the nurse determines that Medical Necessity was lacking, the nurse will refer the case to a licensed clinical peer reviewer

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you and your provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it within 30 calendar days. You or

your provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to you and your provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

- C. **Notice of Adverse Determination.** A notice of adverse determination (notice that a service is not Medically Necessary) will include the reasons, including clinical rationale, for our determination. The notice will also advise you of your right to appeal our determination, give instructions for requesting an external appeal and for initiating an external appeal and specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal. We will send notices of determination to you or your designee and to your health care provider.

If, prior to making an adverse determination, no attempt was made to consult with the provider who recommended the service at issue, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For prospective reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to the provider, by telephone and in writing.

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

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

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

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review, or any other urgent matter, will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request.

If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal. Our failure to render a determination of your internal appeal within 60 calendar days shall be deemed a reversal of the initial adverse determination.

- E. **Notice of Determination of Internal Appeal.** The notice of determination of your internal appeal will indicate that it is a "final adverse determination" and will include the clinical rationale for our decision. It will also explain your rights to an external appeal, together with a description of the external appeal process and the time frames for initiating an external appeal. We will send notices of determination to you or your designee and to your health care provider.

28. **External Appeal.**

- A. **External Appeal in General.** You have the right to an "external appeal" of certain coverage determinations made by us. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by the State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal. "Requested service" or "requested services" refers to the service or services for which you are requesting coverage.

You may have the right to an expedited external appeal if your attending physician attests that a delay in providing the requested service would pose an imminent or serious threat to your health. The timeframes for expedited external appeals are shorter than the timeframes for standard external appeals.

You may request an external appeal only if the requested service is a covered service under this Certificate.

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

In general, you may not request an external appeal unless we have issued a "final adverse determination" of your request for coverage through the first level of the internal appeal process. You may ask us to agree to an external appeal even though you have not obtained a final adverse determination through the first level of the internal appeal process; however, we have no obligation to agree to your request. If we do agree, we will send you a letter stating that we have agreed to an external appeal even though you have not obtained a final adverse determination.

To be eligible for external appeal, the final adverse determination issued through the first level of the internal appeal process must be based on a determination that the requested service is not Medically Necessary, or that the requested service is experimental or investigational. You do not have the right to an external appeal of any other determinations, even if those other determinations affect your coverage.

- C. **Conditions for External Appeals of Determinations of Medical Necessity.** You may request an external appeal of a final adverse determination of Medical Necessity issued through the first level of the internal appeal process if you meet the conditions of this subparagraph and the general requirements of Subparagraph B above. The provisions of this subparagraph apply only to external appeal of Medical Necessity determinations.

To request external appeal under this subparagraph, the final adverse determination must indicate that the requested service is not Medically Necessary. Subparagraph G below provides information on requesting an external appeal.

- D. **Conditions for External Appeals of Determinations Involving Experimental or Investigational Treatment.** This subparagraph governs external appeals of determinations involving experimental or investigational treatment. This subparagraph does not govern determinations involving services provided in clinical trials that are governed by Subparagraph E below.

In order to request an external appeal under this subparagraph, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one that, according to the current diagnosis of your attending physician, has a high probability of causing your death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

In addition, your attending physician must certify: that standard health services or procedures have been ineffective, or would be medically inappropriate in treating your life-threatening condition or disease; or, that no more beneficial standard treatment exists which is a covered service under this Certificate.

Your attending physician must have recommended a health service or procedure (including off-label usage of a pharmaceutical product) which, based on at least two documents from the available medical literature, is likely to be more beneficial to you than any standard covered health service or procedure. To make this recommendation, your attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

If you meet the requirements of this subparagraph and all of the requirements of Subparagraph B, you may request an external appeal. Subparagraph G provides information on requesting an external appeal.

E. External Appeals of Determinations Involving Clinical Trials. This subparagraph governs external appeals of determinations involving services provided in clinical trials.

In order to request an external appeal under this subparagraph, your attending physician must certify that you have a life-threatening or disabling condition or disease as described in Subparagraph D above. In addition, your attending physician must certify that a clinical trial for your condition exists and that you are eligible to participate in the clinical trial.

Your attending physician must also recommend that you participate in the clinical trial. To make this recommendation, your attending physician must be board-certified or board-eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The clinical trial for which you are requesting coverage must be peer-reviewed, reviewed and approved by a qualified Institutional Review Board, and approved by one of the following:

- (1) The National Institutes of Health (NIH), an NIH cooperative group or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs;
- (2) An entity that has been identified by the NIH as a qualified non-governmental research entity; or
- (3) An Institutional Review Board of a facility that has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

If you meet the requirements of this subparagraph and all of the requirements of Subparagraph B, you may request an external appeal. Subparagraph G below provides information on requesting an external appeal.

F. Effect of the External Appeal Agent's Decision; Coverage. The decision of the External Appeal Agent is binding on both parties. If the External Appeal Agent decides in our favor, we will not cover the requested service. If the external appeal agent decides in your favor, we will cover the service as follows:

- (1) For services denied as not Medically Necessary, we will treat the service as Medically Necessary and provide coverage subject to all other conditions of this Certificate.
- (2) For services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of this Certificate.
- (3) For services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of this Certificate. We are not required to pay for drugs or devices that are the subject of the clinical trial.

We will not provide coverage for any service that is not a covered service under this Certificate. In addition, this subparagraph does not alter any cost-sharing responsibilities as otherwise provided for in this Certificate.

G. Requesting an External Appeal. If you meet the conditions described above, you may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your physician may file an appeal on your behalf. We will send a standard request form to you when we have made a final adverse determination at the first level of the internal appeal process. You or your physician may obtain additional standard request forms at any time from the State Insurance Department, the Department of Health, or by contacting us.

You must file your request for an external appeal with the State Insurance Department within 45 days of receiving a final adverse determination as a result of the first level appeal process, or within 45 days of receiving a letter from us waiving the internal review process. We do not have the authority to grant extensions of this deadline.

Additional internal appeals may be available to you which are optional. However, regardless of whether you participate in additional internal appeals, your application for external appeal must be filed with the New York State Department of Insurance within 45 days from your receipt of the notice of final adverse determination from a first level internal appeal in order to be eligible for review by an external appeal agent.

You may be charged a fee of up to \$50 to request an external appeal, which may be waived if we determine that paying the fee is a financial hardship. The fee is returned if your external appeal is successful.

If you do not understand any part of the external appeal process or if you have questions regarding your right to external appeal, you may contact us, the State Insurance Department, or the Department of Health.

29. **Drug Utilization, Cost Management And Rebates.** We conduct 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, your 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 premiums for your coverage. We may, from time-to-time, also enter into agreements that result in us 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 our business and not solely on any one Member's or one group's utilization of Prescription Drugs. Any rebates received by us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of our Prescription Drug premiums. Instead, any such rebates may be retained by us, at our 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. Rebates will not change or reduce the amount of any Copayment, coinsurance or deductibles applicable under our Prescription Drug coverage.
30. **No Liability.** We will not 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 Certificate.



BONE DENSITY SERVICES ENDORSEMENT

Issued by

EXCELLUS HEALTH PLAN, INC.

Independent Licensee of the Blue Cross and Blue Shield Association

This Endorsement amends your Prescription Drug Contract, Certificate, or Group Health Plan by adding or replacing benefits for approved drugs and/or devices for the treatment of osteoporosis. All of the terms, conditions and limitations of the Contract, Certificate, or Group Health Plan to which this Endorsement is attached also apply to this Endorsement, except where they are specifically changed by this Endorsement.

1. **Bone Density Treatment.** We will cover drugs and devices, or their generic equivalents, approved by the Federal Food and Drug Administration for treatment of osteoporosis.
2. **Deductibles, Copayments and Coinsurance.** The benefits of this Endorsement are subject to any applicable deductible, copayment, or coinsurance provision of your Prescription Drug Contract, Certificate, or Group Health Plan that apply to prescription drugs.
3. **New Contract After Termination of Coverage May not Contain the Benefits this Endorsement.** The new contract to which you may be entitled if your coverage under your Contract, Certificate or Group Health Plan ends may not include any of the benefits of this Endorsement.

Excellus Health Plan, Inc.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By:

A handwritten signature in black ink that reads "Christopher C. Booth".

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR CONTRACEPTIVE DRUGS AND DEVICES

Issued by

EXCELLUS HEALTH PLAN, INC.

An Independent Licensee of the BlueCross BlueShield Association

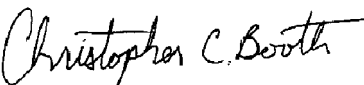
This Rider amends your Contract, Certificate or Group Health Plan that covers prescription drugs by adding or replacing the benefit for contraceptive drugs and/or devices. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached, also apply to this Rider, except where they are specifically changed by this Rider.

1. **Pharmacy Contraceptive Drugs And Devices.** We will cover prescription contraceptive drugs and devices, or generic equivalents, approved by the federal Food and Drug Administration. The drug or device must be prescribed by a health care provider legally authorized to prescribe drugs and be dispensed by a pharmacy. All of the limitations and restrictions applicable to your prescription drug benefit also apply to this benefit.
2. **Office Contraceptive Drugs And Devices.** We will cover contraceptive drugs and devices administered by a Professional Provider, including but 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 applicable to your prescription drug benefit also apply to this benefit.
3. **Deductibles, Copayments And Coinsurance.** The benefits of this Rider are subject to any deductible, copayment or coinsurance provisions of your Contract, Certificate or Group Health Plan that apply to prescription drugs.
4. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Contract, Certificate or Group Health Plan ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



ENDORSEMENT FOR ORALLY-ADMINISTERED ANTICANCER DRUGS

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Endorsement affects certain cost-sharing requirements under your Prescription Drug Rider. All of the terms, conditions, and limitations of the Rider to which this Endorsement is attached also apply to this Endorsement, except where they are specifically changed by this Endorsement.

1. **Cost Sharing for Orally-Administered Anticancer Medications.** Under this Endorsement, your cost sharing (Deductible, Copayment or Coinsurance) for orally-administered anticancer medications covered under your Rider is the cost-sharing amount, if any, that applies to anticancer medications that are administered intravenously or by injection, and are covered under the medical benefits in the Contract, Certificate or Group Health Plan to which your Rider attaches.
2. **New Contract After Termination of Coverage May Not Contain the Benefits of This Endorsement.** The new contract to which you may be entitled if your coverage under your Rider ends may not include any of the benefits of this Endorsement.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer



**ENDORSEMENT FOR SPECIALTY MEDICATION
AND PRIOR AUTHORIZATION, STEP THERAPY REQUIREMENTS**

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Endorsement makes certain changes to the Specialty Medication and prior authorization requirements that apply to the Prescription Drug benefits under your Contract, Certificate or Group Health Plan and any affected Riders or Endorsements thereto (collectively "Health Plan"). All of the terms, conditions and limitations of the Health Plan to which this Endorsement is attached also apply to this Endorsement, except where they are specifically changed by this Endorsement.

1. Specialty Medications.

- A. **Definition.** The Specialty Medications definition in your Rider or Endorsement for Specialty Medication Pharmacy Network is hereby deleted in its entirety and replaced with the following:

Specialty Medications. Covered Prescription Drugs that are: used to treat conditions such as multiple sclerosis, hepatitis C, rheumatoid arthritis, infertility and growth hormone deficiency; and identified on the formulary that is available on our website at www.excellusbcbcs.com or that will be mailed to you upon request. You may request the formulary by calling the number shown on your ID card. Most Specialty Medications are injectables. However, the Specialty Medications on our formulary also include select oral medications, compound medications and other types of covered Prescription Drugs.

- B. **Changes.** The Prescription Drugs that are identified as Specialty Medications may be revised from time to time based on the introduction of new drugs and/or new clinical information, and after review by our Pharmacy and Therapeutics Committee. If our records show that you are taking a Prescription Drug that will be identified on our formulary as a Specialty Medication, we will notify you in writing at least 30 days in advance of the addition of the drug to Specialty Medication category and whether the Specialty Medication is subject to prior authorization as described below.

2. Prior Authorization; Step Therapy Program. The provisions in your Health Plan that describe the prior authorization requirements are hereby deleted in their entirety and replaced with the following:

- A. **Prior Authorization.** We will periodically identify certain Prescription Drugs that, for reasons such as cost, patient safety, and possible use for purposes that are not Medically Necessary or appropriate, will only be filled with prior authorization from us. The Prescription Drugs that require prior authorization are included on the form entitled "Prescription Drugs Requiring Prior Authorization" that is given to you with your Health Plan. The Prescription Drugs that require prior authorization are

also identified on the formulary that is available on our website at www.excellusbcs.com, or that will be mailed to you upon request. You may request the formulary by calling the number shown on your ID card. The Prescription Drugs that require prior authorization may change as described in Subparagraphs C and D below. We therefore encourage you to call us 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.

- (1) **Prior Authorization Procedure.** If you seek coverage for a Prescription Drug that requires prior authorization, you initiate the prior authorization procedure by calling the number on your ID card; and your provider must submit a statement of Medical Necessity to us. After receiving a request for prior authorization, we will review the statement of Medical Necessity and determine if benefits are available. We will notify you and your Professional Provider of our decision 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 we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your Professional Provider, by telephone and in writing, within 72 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour period. A request is "urgent" if it could seriously jeopardize your life or health or the ability to regain maximum function; or if your provider determines that it is urgent, we must treat it as such.

- (2) **Your Right to Appeal.** If you or your Professional Provider disagrees with our decision, you may appeal by following the appeal procedures set forth in your Health Plan.
- (3) **Failure to Seek Authorization.** When you fail to seek our prior authorization of a Prescription Drug that requires such authorization and the drug is dispensed, you must pay the pharmacy the total cost of the drug. If you then submit a claim to us, we will pay only 50% of the amount we would otherwise have paid for the Prescription Drug. We will only pay this amount if we determine the Prescription Drug was Medically Necessary, even though you did not seek our prior authorization. If we determine that the Prescription Drug was not Medically Necessary, we will not make any payment for the drug; and you will be responsible for the entire charge.

- B. **Step Therapy Program.** The Step Therapy Program is a form of prior authorization under which certain Prescription Drugs require prior authorization if a Generic Drug or cost-effective alternative Prescription Drug has not been tried. The Prescription Drugs that require prior authorization under the Step Therapy Program are also included on the form entitled "Prescription Drugs Requiring Prior Authorization" that is given to you with your Health Plan. In addition, these Prescription Drugs are identified on the formulary that is available on our website at www.excellusbcs.com, or that will be mailed to you upon request. You may request the list by calling the number shown on your ID card.
- C. **Prescription Drugs that Receive FDA Approval.** Prior authorization or step therapy applies to all new drugs entering the market upon FDA approval. A new drug will require prior authorization and step therapy until we determine that it satisfies our criteria for safety, efficacy and cost-effectiveness.

- D. **Other Changes.** We may add or change prior authorization or step therapy requirements: on a Brand Name Drug when a therapeutically equivalent Generic Drug becomes available; or to promote safe utilization of a Prescription Drug based on new clinical guidelines or information related to drug safety and effectiveness. These changes will be made following notice to affected Members.
3. **New Contract After Termination of Coverage May Not Contain The Benefits of This Endorsement.** The new contract to which you may be entitled if your coverage under your Health Plan ends may not include any of the benefits of this Endorsement.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield

165 Court Street

Rochester, NY 14647



RIDER FOR EARLY REFILLS OF PRESCRIPTION EYE DROPS

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes certain benefits for prescription eye drops under your Prescription Drug Certificate of Coverage. All of the terms, conditions, and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Early Refills of Prescription Eye Drops.** Notwithstanding anything to the contrary in your Certificate, we will provide coverage for a limited refill of prescription eye drops prior to the last day of the dosage period without regard to coverage restrictions on early refill of renewals. To the extent practicable, the quantity of eye drops in the early refill will be limited to the amount remaining on the dosage that was initially dispensed. Your cost sharing for the limited refill is the amount that applies to each prescription or refill as set forth in your Certificate, or when stated as such, the amount that applies for up to a 30-day supply of a covered Prescription Drug.
2. **New Contract After Termination of Coverage May Not Contain the Benefits of This Rider.** The new contract to which you may be entitled if your coverage under your Certificate ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer



**RIDER TO APPLY MAIL SERVICE PHARMACY BENEFITS TO
PRESCRIPTION DRUGS PURCHASED AT CERTAIN RETAIL PHARMACIES**

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes certain benefits under your Prescription Drug Certificate of Coverage. All of the terms, conditions, and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **When Mail Service Pharmacy Benefits Are Available at a Retail Pharmacy.** Notwithstanding anything to the contrary in your Certificate, we will provide the benefits that apply to drugs dispensed by a Participating mail service Pharmacy to drugs purchased from a Participating retail Pharmacy when that pharmacy has a participation agreement with us in which it agrees to be bound by the same terms and conditions as a Participating mail service Pharmacy. When you purchase Prescription Drugs from a Participating retail Pharmacy that has agreed to the same terms and conditions as a Participating mail service Pharmacy, we will apply the same cost sharing, day supply and other conditions that apply to Prescription Drugs you purchase from a Participating mail service Pharmacy.
2. **New Contract After Termination of Coverage May Not Contain the Benefits of This Rider.** The new contract to which you may be entitled if your coverage under your Certificate ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: *Christopher C. Booth*

Christopher C. Booth
President and Chief Executive Officer



**PRESCRIPTION DRUGS FOR SUBSTANCE USE DISORDER
TREATMENT RIDER**

**Issued by
EXCELLUS HEALTH PLAN, INC.**

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds certain benefits for Prescription Drugs for substance use disorder treatment under Your Prescription Drug Certificate of Coverage. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

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

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

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

2. **Initial Limited Supply of Prescription Opioid Drugs.** If You receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be the same Copayment that would apply to a 30-day supply of the Prescription Drug. If You receive an additional supply of the Prescription Drug within the same 30-day period in which You received the seven (7) day supply, You will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.
3. **New Contract after Termination of Coverage May Not Contain The Benefits of this Rider.** The new contract to which you may be entitled if your Certificate ends may not include any of the benefits of this Rider.

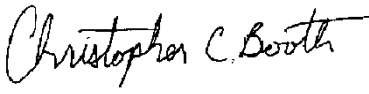
EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield

165 Court Street

Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



RIDER FOR PRESCRIPTION DRUG STEP THERAPY OVERRIDE DETERMINATIONS

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds certain benefits for Prescription Drugs for Step Therapy Override Determinations under Your Prescription Drug Certificate of Coverage. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Step Therapy Override Determinations.** You, Your designee, or Your Health Care Professional may request a step therapy protocol override determination for Coverage of a Prescription Drug selected by Your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We 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 Health Care Professional, 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 Us 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 Health Care Professional for Your medical condition, provided this does not prevent Us 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.** We will make a step therapy protocol override determination and provide notification to You (or Your designee) and where appropriate, Your Health Care Professional, 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 Health Care Professional, We will make a step therapy protocol override determination and provide notification to You (or Your designee) and Your Health Care Professional 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, We 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 Health Care Professional will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our 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, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours or one (1) business day of Our 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, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our 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, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 24 hours of Our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If We do 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 We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

2. **New Contract after Termination of Coverage May Not Contain The Benefits of this Rider.** The new contract to which you may be entitled if your Certificate ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: 

Christopher C. Booth
President and Chief Executive Officer



**RIDER FOR
SPECIALTY MEDICATION PHARMACY NETWORK**

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider changes certain benefits for prescription drugs under your Contract, Certificate or Group Health Plan. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Definitions.**

- A. **Specialty Medications.** Prescription Drugs covered under your Contract, Certificate or Group Health Plan that are: used to treat conditions such as multiple sclerosis, hepatitis C, rheumatoid arthritis, infertility and growth hormone deficiency; and included on the form entitled "List of Specialty Medications" that applies to this Rider. Most Specialty Medications are injectables. However, our list also includes select oral medications, compound medications and other types of covered Prescription Drugs.

Our List of Specialty Medications may be revised from time-to-time based on the introduction of new drugs and/or new clinical information, and after review by our Pharmacy and Therapeutics Committee. If our records show that you are taking a Prescription Drug that will be added to the List of Specialty Medications, we will notify you in writing at least 30 days in advance of the addition of the drug to the list. A current List of Specialty Medications can be obtained by writing or calling our office and is available on our website at the address in Subparagraph B below.

- B. **Specialty Pharmacy Network.** Retail and specialty pharmacies that have agreements with us to dispense Specialty Medications to our Members. We have a list of the pharmacies that participate in the Specialty Pharmacy Network. You will receive a copy of the list with this Rider and may request a copy in writing or by telephone, or you may view a copy of the list on our website at: www.excellusbcb.com.

2. **You Must Obtain Specialty Medications Through The Specialty Pharmacy Network.** In order to receive coverage for a Specialty Medication under your Contract, Certificate or Group Health Plan, you must obtain the drug from a Specialty Pharmacy Network pharmacy. If you do not comply with this requirement, you must pay the full cost of the Specialty Medication. As described in Paragraph 3 below, the initial fill of a Specialty Medication is the only exception.
3. **Initial Fill Exception.** The requirements of this Rider will not apply to the initial fill of a Specialty Medication. We will provide coverage for the initial fill of a Specialty Medication as set forth in your Contract, Certificate or Group Health Plan. Thereafter, you must obtain the Specialty Medication through the Specialty Pharmacy Network.

4. **Days' Supply.** We will provide benefits for Specialty Medications in a quantity of up to the days' supply limit that, according to your Contract, Certificate or Group Health Plan, or any Rider or Endorsement thereto, applies to Prescription Drugs dispensed by a retail pharmacy.
5. **Benefits.** Benefits under this Rider will be subject to the cost-sharing requirements in your Contract; Certificate or Group Health Plan that apply to drugs dispensed by a participating retail pharmacy. Any Deductible, Copayment or Coinsurance that applies to Prescription Drugs dispensed by a participating retail pharmacy that are in the same tier, or of the same type (Generic or Brand Name), as your Specialty Medication(s) will apply to drugs under this Rider.
6. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Contract, Certificate or Group Health Plan ends may not include any of the benefits of this Rider.

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: 

Christopher C. Booth
President and Chief Executive Officer

List of Participating Speciality Pharmacy Network Pharmacies

This list is subject to change. Updated list can be found on our website:
<https://www.excellusbcbs.com/wps/portal/xl/mbr/drg/speciality/>

PREFERRED SPECIALTY PHARMACIES

ACCREDITO HEALTH GROUP
1640 CENTURY CTR PKY #101
MEMPHIS, TN 38134
1-866-413-4137

**WALGREENS SPECIALTY
PHARMACY**
41460 HAGGERTY CIRCLE
SOUTH
CANTON, MI 48188
1-866-435-2170

**CYSTIC FIBROSIS SERVICES
(Walgreens)**
2019 ALEXANDER DR STE 2A
DOTHAN, AL 36301
1-800-541-4959

OTHER SPECIALTY PHARMACY

NOBLE PHARMACY
6040 TARBELL RD
SYRACUSE, NY 13206
1-888-843-2040

ONCOLOGY SPECIALTY PHARMACIES

ONCO360 PHARMACY
640 ELLICOTT ST STE 301
BUFFALO, NY 14203
1-877-662-6633

CCS ONCOLOGY
45 SPRINDRIFT DR STE 100
WILLIAMSVILLE, NY 14221
1-716-565-0355

**HOA - THE PATIENT RX
CENTER**
5008 BRITTONFIELD PKWY
STE 700
EAST SYRACUSE, NY 13057
1-315-472-7504

LOCAL SPECIALTY PHARMACIES

CLINIC PHARMACY
1 GUTHRIE SQUARE
SAYRE, PA 18840
1-570-882-2800

COTTRILL'S PHARMACY, INC
455 MAIN ST
ARCADE, NY 14009
1-844-895-1093

MILLER'S PHARMACY
201 SCOTTSVILLE-W HEN RD
STE 1
WEST HENRIETTA, NY 14586
1-585-889-3510

ROSWELL PARK OUTPATIENT
ELM & CARLTON ST
BUFFALO, NY 14263
1-716-845-8996

STRONG MEMORIAL HOSPITAL
601 ELMWOOD AVE BOX 638
ROCHESTER, NY 14642
1-585-275-4931

**STRONG HEALTH PHARMACY
AT JORDAN**
83 HOLLAND ST
ROCHESTER, NY 14605
1-585-423-5802

UPSTATE PHARMACY
40 NORTH AMERICA DR
STE 100
WEST SENECA, NY 14224
1-716-675-3784

CITY DRUGS
1752 FIRST AVE
NEW YORK, NY 10128
1-212-988-4500

LIFETIME PHARMACIES

**LIFETIME HLTH MED GRP
PHCY**
1185 SWEET HOME RD
AMHERST, NY 14226
1-716-614-5797

**LIFETIME HLTH MED GRP
PHCY**
151 ELMVIEW AVE
HAMBURG, NY 14075
1-716-857-6260

**LIFETIME HLTH MED GRP
PHCY**
800 CARTER ST
ROCHESTER, NY 14621
1-585-338-4972

**LIFETIME HLTH MED GRP
PHCY**
77 SULLYS TRAIL
PITTSFORD, NY 14534
1-585-248-8340

**LIFETIME HLTH MED GRP
PHCY**
899 MAIN ST
BUFFALO, NY 14203
1-716-614-5799



A nonprofit independent licensee of the BlueCross BlueShield Association

Annual Disclosure Notice

Under federal law we are required to notify you of the following benefits under your contract(s) or certificate(s) in connection with mastectomies. **PLEASE NOTE THAT YOUR BENEFITS UNDER YOUR CONTRACTS OR CERTIFICATES HAVE NOT CHANGED.**

- **If your contract or certificate provides benefits for inpatient hospital care:** New York State law mandates coverage for the inpatient hospital stay that you and your attending physician determine is appropriate for you after undergoing a lymph node dissection or lumpectomy for the treatment of breast cancer, or after a covered mastectomy.
- **If your contract provides medical and/or surgical benefits:** New York State and federal law mandate coverage for professional provider services, as determined by you and your attending physician, in connection with the following:
 - Reconstruction of the breast on the breast on which the mastectomy was performed;
 - Surgery and reconstruction of the other breast, to produce a symmetrical appearance; and
 - Prostheses and physical complications at all stages of mastectomy, including lymphedema.

The benefits are subject to the referral and cost-sharing (deductible, copayment, and/or coinsurance) requirements of your contract, as described in the contract(s) or certificate(s) or rider describing these benefits.

THE NEW YORK CONSUMER GUIDE TO HEALTH INSURERS

The New York Consumer Guide to Health Insurers
evaluates the performance of HMOs and other insurers.

TO OBTAIN YOUR FREE COPY, WRITE TO:

New York State Department of Financial Services
Publications Unit
Agency Building One, 5th Floor
Albany, New York 12257

Or e-mail your request to:
Publicat@dfs.ny.gov

Guides are also available through the
New York State Department of Financial Service's Website:
www.dfs.ny.gov

Please send a copy of the current *New York Consumer Guide to Health Insurers* to:

NAME: _____

ADDRESS: _____

CITY/STATE: _____

ZIP CODE: _____



165 Court Street
Rochester, New York 14647

A nonprofit independent licensee of the BlueCross BlueShield Association

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

This notice takes effect April 14, 2003.

OUR COMMITMENT TO YOUR PRIVACY

We understand that medical information about you and your health is personal. We are committed to safeguarding your protected health information (PHI).

PHI is any information that can identify you as an individual and your past, present or future physical or mental health condition.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. The law requires us to:

- make sure that PHI that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to PHI about you; and
- follow the terms of the notice that is currently in effect.

OUR LEGAL DUTY

We (**Excellus BlueCross BlueShield**) are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning PHI. We must follow the privacy practices that are described in this notice while it is in effect, including notification should there be a breach of your unsecured PHI.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the contact information at the end of this notice.

Uses and Disclosures of Nonpublic Personal Information

Nonpublic Personal Information is information you give us on your enrollment form, claim forms, premium payments etc. For example: names, member identification number, social security number, addresses, type of health care benefits, payment amounts, etc.

We will not give out your nonpublic personal information to anyone unless we are permitted to do so by law or have received a signed authorization form from the member. You may revoke this authorization in writing by completing an authorization cancellation form at any time. This revocation will not affect any actions we took in reliance on your authorization before your authorization cancellation form was processed.

Uses and Disclosures of Medical Information

The following categories describe different purposes for which we use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. If we need to use or disclose your PHI in any other way, we will obtain your signed authorization before our use or disclosure. You may revoke this authorization in writing by completing an authorization cancellation form at any time. This revocation will not affect any actions we took in reliance on your authorization before your authorization cancellation form was processed.

Treatment: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to doctors or hospitals involved in your care. For example, we may disclose your medications to an emergency room physician so that he/she can avoid dangerous drug interactions. This allows providers to manage, coordinate and administer treatment.

Payment: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use and disclose PHI to collect premiums, to determine our responsibility to pay claims or to notify members and providers of our claim determinations. We may disclose PHI to providers to assist them in their billing and collection efforts. We may also disclose PHI to other insurance companies to coordinate the reimbursement of health insurance benefits. For example, we may disclose PHI to an automobile no-fault insurance company to determine responsibility for claim payment. Also, if you have health insurance through another insurance company, we may disclose PHI to that other health insurance company in order to determine which company holds the responsibility for your claims.

Healthcare Operations: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use and disclose PHI for purposes of performing our healthcare operations. Our healthcare operations include using PHI to determine premiums, to conduct quality assessment and improvement activities, to engage in care coordination or case management, to determine eligibility for benefits. For example, we may use or disclose PHI when working with accreditation agencies that monitor and evaluate the quality of our benefit programs.

To You: We must disclose your PHI to you, as described in the Individual Rights section of this notice, below. We may also use and disclose PHI to tell you about recommended possible treatment options or alternatives or to tell you about health related benefits or services that may be of interest to you.

To Family and Friends: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. If you agree or, if you are unable to agree when the situation, (such as medical emergency or disaster relief), indicates that disclosure would be in your best interest, we may disclose PHI to a family member, friend or other person. In an emergency situation, we will only disclose the minimum amount necessary.

To Our Business Associates: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. A business associate is defined as someone that assists us in managing our business. For example, a professional that reviews the quality of our products and services. We may disclose PHI to another company that helps us manage our business. For example, we may disclose PHI to a company that performs case reviews to ensure our members receive quality care. These business associates are required to sign a confidentiality agreement with us that limits their use or disclosure of the PHI they receive.

To Plan Sponsors: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. A plan sponsor is defined as the employer or employee organization that establishes and maintains the employee's benefit plan. If you are enrolled in a group health plan, we may disclose PHI to the plan sponsor to permit the plan sponsor to perform plan administrative functions. For example, the cost analysis of the benefit program. Before PHI is disclosed to your plan sponsor, we will receive certification from the plan sponsor that appropriate amendments have been made to group health plan document(s) and the plan sponsor agrees to limit their use or disclosure of this information to plan administration functions only.

Research: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use or disclose PHI for research purposes in limited circumstances. For example, a research project may involve comparing the health and recovery of all members who received one medication to those who received another medication for the same condition. All research projects are required to obtain special approval.

Coroners, Medical Examiners and Funeral Directors: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may release PHI to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release PHI about deceased members to funeral directors in order for the funeral directors to carry out their duties.

Organ Donation: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, to facilitate organ or tissue donation and transplantation. This may include a living donor as well as a deceased donor.

Public Health and Safety: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose PHI to a government agency authorized to oversee the healthcare system or government programs or its contractors, and to public health authorities for public health purposes.

Victims of Abuse, Neglect or Domestic Violence: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Required by Law: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use or disclose PHI when we are required to do so by law. For example, we must disclose PHI to the U.S. Department of Health and Human Services upon request to determine whether we are in compliance with federal privacy laws.

Process and Proceedings: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose PHI to law enforcement officials.

Law Enforcement: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to a law enforcement official investigating a suspect, fugitive, material witness, crime victim or missing person. We may disclose PHI of an inmate or other person in lawful custody of a law enforcement official or correctional institution under certain circumstances.

Military and National Security: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose to the military, PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence, and other national security activities.

Marketing and Fundraising: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. To the extent we use PHI for marketing or fundraising purposes, you will be contacted by us and have the right to opt out of receiving these communications from us and our use of your information for such purposes.

Genetic Nondiscrimination Act (GINA): We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We will not disclose your PHI containing genetic information for underwriting purposes. GINA expressly prohibits the use or disclosure of genetic information for these purposes.

Breach of Unsecured Information: We will notify you should there be a breach of unsecured information. We are required to notify you if there is any acquisition, access, use, or disclosure of your unsecured PHI that compromises the security or privacy of your PHI.

Psychotherapy Information: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. Should it be applicable that your psychotherapy notes be included in an appropriate use or disclosure of information, in most instances, we are required to obtain your authorization for the release of this information.

Individual Rights

Access: You have the right to inspect and/or copy your PHI, with limited exceptions such as information a licensed health care professional, exercising professional judgment, determines that providing access is reasonably likely to endanger the life, physical safety or cause someone substantial harm. You may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us. If you request copies, we reserve the right to charge you a reasonable fee for each copy, plus postage if the copies are mailed to you.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your PHI. The list will not include disclosures we made for the purpose of treatment, payment, healthcare operations, disclosures made with your authorization, or certain other disclosures. To request a disclosure accounting you may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us. The request may not exceed a six year time period. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed and the reason for the disclosure. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. As permitted by law, we will not honor these requests, as it prohibits us from administering your benefits.

Confidential Communication: You have the right to request that we communicate with you confidentially about your PHI. We will honor a request to communicate to an alternative location if you believe you would be endangered if we do not communicate to the alternative location. We must accommodate your request if it is reasonable and specifies the alternative location. To request a form to be completed and returned to us, you may contact us using the telephone number on the back of your identification card.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or if we determine the information is accurate. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be attached to the information you wanted amended. You may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the contact information at the end of this notice to obtain this notice in written form.

Safeguards

It is our policy to keep all information about you confidential in all settings. It is so important to us that we take the following steps:

- our employees sign an agreement to follow our Code of Business Conduct;
- our employees are required to complete our privacy training program;
- we have implemented the necessary sanctions for violation of our privacy practices;
- we have a privacy oversight committee that reviews our privacy practices;
- we have a security coordinator to detect and prevent security breaches;
- all computer systems that contain personal information have security protections; and
- we randomly check provider offices on a routine basis to ensure that medical records are kept in secure locations.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the contact information at the end of this notice.

If you are concerned that we may have violated your privacy rights, as described above, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us confidentially communicate with you at an alternative location, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Rights or Questions:

Contact Office: Customer Care

Phone: Please call the telephone number on your identification card.

Privacy Complaints:

Contact Office: Privacy Officer

Address: 333 Butternut Dr.
Dewitt, NY 13214-1803

Phone: 1-866-584-2313

E-mail: privacy.officer@excellus.com

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The Health Plan:

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

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意: 如果您说中文, 我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlop la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.



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