LIBERTY UTILITIES

2023 BENEFIT BOOKLET FOR THE PPO $250 BENEFITS OPTION

This booklet explains the medical and prescription drug benefits available to you under the PPO $250 benefits option of the medical plan maintained by Liberty Utilities (the "Benefit Plan"). The medical and prescription drug benefits available under the Benefit Plan are self-funded and are funded by Liberty Utilities (the "Group"). Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield, Rochester Region ("Excellus BlueCross BlueShield" or the "Claims Administrator"), administers claims for benefits under the Benefit Plan on behalf of the Group and does not insure your benefits. Excellus BlueCross BlueShield provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims. Excellus BlueCross BlueShield is a nonprofit independent licensee of the BlueCross BlueShield Association. You should keep this booklet with your other important papers so it is available for your future reference.

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

In-Network Benefits. In-Network Benefits are the highest level of coverage available. In-Network Benefits apply when your care is provided by In-Network Providers. You should always consider receiving health services first through In-Network Providers.

Out-of-Network Benefits. The Out-of-Network Benefits portion of this Benefit Plan covers health care services described in this booklet when you choose to receive the covered services from Out-of-Network Providers. When you receive Out-of-Network Benefits, you will incur the highest out-of-pocket expenses because in addition to any applicable Deductible you will be responsible for paying any difference between the Allowable Expense and the provider's charge.

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

TABLE OF CONTENTS

PAGE

SECTION ONE - INTRODUCTION AND DEFINITIONS

1. **Your Coverage under This Benefit Plan.** The terms of this self-funded Benefit Plan are effective as of January 1, 2023, unless otherwise stated herein. Under the Benefit Plan, the benefits described in this booklet will be provided to employees and their covered family members, subject to the Group's eligibility requirements. You should keep this booklet with your other important papers so that it is available for your future reference.

2. **Definitions.**

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

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

   Prescription Drug Benefits. The Allowable Expense for Prescription Drug benefits (other than with respect to COVID-19 OTC tests) under the Benefit Plan from an In-Network Pharmacy is the Prescription Drug Cost before any applicable Coinsurance, Copayment and Deductible Amounts are subtracted. To the extent the Allowable Expense is less than your Copayment, you will pay the Allowable Expense. The Allowable Expense for COVID-19 OTC tests from an In-Network Pharmacy is the Average Wholesale Price discounted rate.

   Medical Benefits. The Allowable Expense for In-Network Providers will be determined as follows:

   (1) **In-Network Facilities in the Service Area**.
   For an in-network Facility in the Service Area, the Allowable Expense will be the amount the Benefit Plan has negotiated with the Facility.

   (2) **In-Network Facilities Outside the Service Area.**
   For an in-network Facility outside the Service Area, the Allowable Expense will be the amount the Benefit Plan has negotiated with the Facility or the amount approved by another Blue Cross and/or Blue Shield plan.

   (3) **For All Other In-Network Providers in the Service Area**.
   For all other In-Network Providers in the Service Area, the Allowable Expense will be the amount the Benefit Plan has negotiated with the In-Network Provider.

   (4) **For All Other In-Network Providers Outside the Service Area.**
   For all other In-Network Providers outside the Service Area, the Allowable

Expense will be the amount the Benefit Plan has negotiated with the In-Network Provider or the amount approved by another Blue Cross and/or Blue Shield plan.

When the In-Network Provider's charge is less than the amount the Benefit Plan has negotiated with the In-Network Provider, the covered Person's Copayment, Deductible or Coinsurance amount will be based on the In-Network Provider's charge.

The Benefit Plan's payments to In-Network Providers may include financial incentives to help improve the quality or coordination of care and promote the delivery of covered services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific covered service provided to you. Your Cost-Sharing will not change based on any payments made to or received from In-Network Providers as part of the financial incentive program.

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

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

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

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

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

(3) **For all other Out-of-Network Providers in the Service Area.**
For all other Out-of-Network Providers in the Service Area, the Allowable Expense will be 80% of the Centers for Medicare and Medicaid Services Provider ("CMMSP") fee schedule, as applicable to the provider type unadjusted for geographic locality, or the Out-of-Network Providers charge, if less.

If there is no CMMSP amount as described above, the Allowable Expense will be 75% of the Out-of-Network Providers charge.

(4) **For all other Out-of-Network Providers Outside the Service Area.**
For all other Out-of-Network Providers outside the Service Area, the Allowable Expense will be 150% of the Centers for Medicare and Medicaid Services Provider ("CMMSP") fee schedule, as applicable to the provider type unadjusted for geographic locality, or the Out-of-Network Providers charge, if less.

If there is no CMMSP amount, as described above, the Allowable Expense will be 75% of the Out-of-Network Providers charge.

(5) **Ground Ambulance.** The Allowable Expense for an Out-of-Network Provider for ground ambulance (other than ground ambulance that constitutes Emergency Services) will be the Out-of-Network Provider's charge.

(6) **Surprise Bills.** The Allowable Expense for surprise bills for an Out-of-Network Provider will be the lesser of the Out-of-Network Provider's charge or the "qualifying payment amount". Please refer to the section entitled "Protection from Surprise Bills" for what constitutes a surprise bill and for how the "qualifying payment amount" is determined.

(7) **In Vitro Diagnostic Test for the Detection of SARS-CoV-2.** Effective as of March 13, 2020, the Allowable Expense for an Out-of-Network Provider for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 is the Out-of-Network Provider's publicly listed price for such test, or such lower rate as the Claims Administrator may negotiate with the Out-of-Network Provider. Effective as of January 15, 2022, during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), COVID-19 OTC tests are covered as described in the Prescription Drug Benefits section of this Plan, with the Allowable Expense for an Out-of-Network Pharmacy for COVID-19 OTC tests being equal to the actual cost of the test or, if lower and if the test was obtained after January 27, 2022, $12 per test. For purposes of the preceding sentence, an expense will be treated as incurred through an Out-of-Network Pharmacy, if the Member pays the retail cost of the COVID-19 OTC test and submits a paper claim for the expense, even if the item is purchased at In-Network Pharmacy. Effective on or after May 12, 2023, COVID-19 OTC test are not Covered and the Allowed Amount for an Out-of-Network Provider for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 will be determined in accordance with (1) through (4) above, as applicable.

(8) **Physician-Administered Pharmaceuticals.**
For Physician-administered pharmaceuticals, the Benefit Plan uses methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published

acquisition costs or Average Wholesale Price for the pharmaceuticals. These methodologies are currently created by the Benefit Plan and reviewed on a periodic basis to ensure the appropriate payment methodology is assigned to all drugs. Pricing resources can include references such as IPD Analytics, Medispan, First Data Bank, or Thomson Reuters (published in its Red Book).

The Allowable Expense is not based on UCR. The Out-of-Network Provider's actual charge may exceed the Allowable Expense. For anything other than surprise bills, you must pay the difference between the Allowable Expense and the Out-of-Network Provider's charge. Please refer to the section entitled "Protection from Surprise Bills" for what constitutes a surprise bill. Medicare based rates referenced in and applied under this section shall be updated no less than annually.

The Benefit Plan reserves the right to negotiate a lower rate (other than with respect to surprise bills) with Out-of-Network Providers or to pay a Blue Cross and/or Blue Shield host plan's rate, if lower.

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

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

E. **Copayment.** A charge, expressed as a fixed dollar amount that you must pay for Prescription Drugs covered under this Benefit Plan. You are responsible for the payment of any Prescription Drug Copayments directly to the Participating Pharmacy when Prescription Drug benefits are rendered.

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

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

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

I. **Emergency Condition.** A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

(2) Serious impairment to such person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of such person.

Examples of medical conditions that are considered to be Emergency Conditions include heart attacks, poisoning and multiple traumas.

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

J. **Emergency Services.** With respect to an Emergency Condition, a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA) or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) which is within the capability of the emergency department of a Hospital (or Independent Freestanding Emergency Department), including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital (or Independent Freestanding Emergency Department) and such further medical examination and treatment as are required to stabilize the patient, regardless of the department of the Hospital in which further examination or treatment is furnished. Emergency Services also includes certain post-stabilization services, unless the following conditions are met:

(1) The attending emergency physician or treating provider has determined that you are able to travel using nonmedical transportation or non-emergency medical transportation to an available In-Network Provider or Facility located within a reasonable travel distance, taking into account your medical condition and any other relevant factor;

(2) If the provider is an Out-of-Network Provider, (a) the provider gives you notice that the services rendered will be performed by an Out-of-Network Provider and you consent to waive your rights to the protections under the surprise bill requirements, and (b) you or your authorized representative are in a condition to provide informed, voluntary consent. See the section of this document entitled Protections from Surprise Bills for additional information; and

(3) The provider satisfies any additional applicable state law requirements and any additional requirements provided in guidance issued by the Department of Health and Human Services.

K. **Essential Health Benefit.** An Essential Health Benefit has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act. Essential Health Benefits include the following general categories and the items and services covered within such categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use services (including behavioral health treatment); Prescription Drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic and disease management; and pediatric services, including oral and vision care.

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

M. **Hospital.** Any short-term acute general hospital facility that is accredited as a hospital by JCAHO; is certified under Medicare; and, if located in New York State, is licensed pursuant to Article 28 of the Public Health Law of New York. A Hospital is a licensed institution primarily engaged in providing:

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

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

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

None of the following are considered Hospitals:

(1) Places primarily for nursing care;

(2) Skilled Nursing Facilities;

(3) Convalescent homes or similar institutions;

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

(5) Health resorts; spas; or sanitariums;

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

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

(8) Free standing ambulatory surgical centers.

N. **Independent Freestanding Emergency Department.** A health care facility that provides Emergency Services and is geographically separated and distinct and licensed separately from a Hospital under applicable State law.

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

P. **In-Network Provider.** A Facility, Professional Provider, or Provider of Additional Health Services who has a contract with the Claims Administrator or another Blue Cross and/or Blue Shield plan to provide services to you at a discounted rate. In-Network Providers have agreed to accept the discounted rate as payment in full for services covered under the Benefit Plan. A list of In-Network Providers is included in a provider directory and is available at www.excellusbcbs.com or upon request by calling the customer service number located on your identification card. The list may be revised from time to time.

The In-Network Provider directory will give you the following information about In-Network Providers:
(1) Name, address, and telephone number;
(2) Specialty;
(3) Board certification (if applicable);
(4) Languages spoken; and
(5) Whether the In-Network Provider is accepting new patients.

You are only responsible for any In-Network Provider Copayment, Deductible or Coinsurance that would apply to the covered services, and you will not be responsible for paying for any Out-of-Network Provider charges that exceed your In-Network Provider Copayment, Deductible or Coinsurance, if you receive covered services from a provider who is not an In-Network Provider because you

reasonably relied on incorrect information provided to you about whether the provider was an In-Network Provider in the following situations:

(1) The provider is listed as an In-Network Provider in the online provider directory;
(2) The paper provider directory listing the provider as an In-Network Provider is incorrect as of the date of publication;
(3) You were given written notice that the provider is an In-Network Provider in response to your telephone request for network status information about the provider; or
(4) You are not provided with written notice within one business day of your telephone request for network status information.

Q. **Life-Threatening Condition.** Any disease or condition from which the likelihood of death is probable unless the course of the disease or the condition is interrupted.

R. **Lifetime Maximum.** The maximum benefit payable during an individual's lifetime while covered under this Benefit Plan. This Benefit Plan may provide for a Lifetime Maximum benefit for a specific type of covered service or treatment. Any Lifetime Maximum will be shown in the section of this booklet where the benefit is described.

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

T. **Medical Necessity or Medically Necessary.** See Section Three.

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

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

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

X. **Out-of-Network Provider.** A Facility, Professional Provider or Provider of Additional Health Services that does not have a contract with the Claims Administrator or another Blue Cross and/or Blue Shield plan to provide services

to you. You will pay higher cost-sharing to see an Out-of-Network Provider as compared to an In-Network Provider.

Y. **Out-of-Pocket Limit.** The most you pay during a Calendar Year in Deductibles, Copayments and Coinsurance before the Benefit Plan begins to pay 100% of the Allowable Expense for covered services. This limit never includes balance billing charges, preauthorization penalty amounts (if any) or the cost of health care services not covered under the terms and conditions of the Benefit Plan.

Z. **Prescription Drug Cost:** The Prescription Drug Cost for an In-Network Pharmacy will be the lesser of the (i) negotiated Average Wholesale Price discounted rate (plus applicable dispensing fee, administration fee and taxes); (ii) applicable Maximum Allowable Cost (plus dispensing fee, administration fee and taxes); or (iii) the pharmacy's Usual and Customary Charge.

AA. **Professional Provider.** A certified and licensed physician; osteopath; dentist; optometrist; chiropractor; registered psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; licensed midwife; speech-language pathologist; audiologist; or licensed pharmacist certified to administer immunizing agents. The Professional Provider's services must be rendered within the lawful scope of practice for that type of provider in order to be covered under this Benefit Plan.

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

CC. **Qualified Clinical Trial.** A phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition and is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(1) The National Institutes of Health;

(2) The Centers for Disease Control and Prevention;

(3) The Agency for Health Research and Quality;

(4) The Centers for Medicare & Medicaid Services;

(5) A cooperative group or center of any of the entities described in (1) through (4) above or the Department of Defense or the Department of Veterans Affairs;

(6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(7) The Department of Veterans Affairs, Department of Defense, or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review that Health and Human Services determines (i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

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

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

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

HH. **Usual and Customary Charge:** The Usual and Customary Charge is the pharmacy's drug retail price list for the Prescription Drug or, if the Prescription Drug is not on the drug retail price list, the usual and customary price for that Prescription Drug. For purposes of this section, the "usual and customary price" is the lowest price, including any dispensing fee, a In-Network Pharmacy would charge a particular customer without insurance coverage if such customer were

paying cash for the identical Prescription Drug on the date dispensed. This includes any customer discounts the In-Network Pharmacy may offer to the general public.

II. **"You", "Your" and "Yours".** Throughout this booklet, the words "you", "your" and "yours" refers to you, the employee, to whom this booklet was issued. If other than individual coverage applies, then in most cases the words "you", "your" and "yours" also includes any family members who are covered under this Benefit Plan.

SECTION TWO - WHO IS COVERED

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Your child who is under the age of 26. Coverage lasts until the end of the month in which your child turns age 26. Your child need not be: financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as students; or unmarried. A spouse or domestic partner of a child is not covered.

D. Your unmarried child who is incapable of self-sustaining employment by reason of a Mental Health Disorder, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attaining age 26 shall continue to be covered while your coverage under this Benefit Plan remains in effect and the child remains in such condition, if you submit proof of your child's incapacity within 31

days of your child attaining age 26. The Group and the Claims Administrator have the right to request proof as to whether or not your child continues to qualify under this provision.

The term "child" includes: your natural child; legally adopted child; step child; a child of a domestic partner; a child for which you have been appointed legal guardian or granted legal custody by court order; and a child for whom you are the proposed adoptive parent and for whom you have a legal obligation for total or partial support during the waiting period prior to the adoption period.

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

2. **Newborn Child.** If you have a type of coverage that would cover a newborn, your newborn child will be covered at birth, provided you notify the Group within 30 days of the birth by completing the enrollment form to add the child to your coverage. If you are changing your type of coverage (for example, from individual to family coverage) in order to cover the newborn child, you must complete the enrollment form and submit it to the Group, to expand your coverage to include your child within 30 days of the birth. If you do not submit the form to the Group within 30 days of the birth, coverage of the child will not become effective until the date to which the Group's next open enrollment period applies. If a child of yours who is covered under this Benefit Plan gives birth, your newborn grandchild will not be covered (unless you are appointed legal guardian or granted legal custody of such child). In this case your grandchild will be covered the same as any other child in accordance with Subparagraph 1.C and D above).

3. **Adopted Newborns.** If you have a type of coverage that will cover a newborn, or switch to a type of coverage that will cover a newborn, coverage will be available for a proposed, adopted newborn from the moment of birth, if you, the proposed adoptive parent:

   A. Notify the Group in accordance with paragraph 2 above; and

   B. Take physical custody of the infant as soon as the infant is released from the Hospital after birth; and

   C. File a petition within 30 days of the infant's birth pursuant to §115-C of the New York State Domestic Relations Law or a comparable provision when the child is adopted in another state.

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

4. **Types of Coverage Offered under the Benefit Plan.** In addition to individual coverage, family coverage is also offered under the Benefit Plan. Family coverage applies, when you, the employee, your spouse or domestic partner and your child or children as described in Subparagraph 1.C and D above are covered.

   The names of all persons covered under this Benefit Plan must have been specified on the enrollment form for this Benefit Plan or provided to the Group as described in paragraph 7 below. No one else can be substituted for those persons. The Group and the Claims Administrator have administrative rules to determine which types of coverage are available to employees and members of the Group. You are only entitled to the types of coverage for which the Group (or the Claims Administrator on behalf of the Group) receives your contribution and that the Group's and the Claims Administrator's records indicate is applicable. You may call the Group or the Claims Administrator if you have any questions about which type of coverage applies to you.

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

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

   B. If you, the employee, do not elect coverage upon becoming eligible or within 30 days of becoming eligible, you must wait until the Group's next open enrollment period, except as provided in paragraph 6 below. When you enroll during the next open enrollment period, coverage then begins at 12:01 a.m. on the date to which the open enrollment period applies.

   C. If you, the employee, marry or enter into a domestic partnership while covered, and the Group receives notice of the marriage or commencement of the domestic partnership within 30 days thereafter, coverage for your spouse or domestic partner starts at 12:01 a.m. on the date of your marriage or domestic partnership. If the Group does not receive notice of the marriage or domestic partnership within the 30-day period; and, if you are changing from individual to family coverage, and the Claims Administrator does not receive a completed change of coverage form; your spouse or domestic partner (as applicable) must wait until the next open enrollment period for coverage. When your spouse or domestic partner is enrolled during the next open enrollment period, coverage for your

spouse or domestic partner will start at 12:01 a.m. on the date to which the open enrollment period applies.

6. **When You Reject Initial Enrollment or Elect Not to Enroll During Open Enrollment, but Do Not Need to Wait until the Group's Next Open Enrollment Period to Enroll for Coverage.** If you, the employee, reject initial enrollment under the Benefit Plan, or elect not to enroll during a subsequent open enrollment, you may enroll for coverage if the following conditions are met:

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

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

      (1) Termination of employment;

      (2) Termination of the other plan or contract;

      (3) Death of the spouse or domestic partner;

      (4) Legal separation, divorce or annulment, or termination of a domestic partnership;

      (5) Reduction in the number of hours worked;

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

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

      (8) Cessation of eligible child status;

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

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

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

E. You apply for coverage under this Benefit Plan within 30 days after termination for one of the reasons set forth in Subparagraph B above, or acquisition of a family member as set forth in Subparagraph C above; or you apply for coverage under this Benefit Plan within 60 days after the occurrence of an event set forth in Subparagraph D above.

If you enroll for coverage pursuant to Subparagraphs A and B, or Subparagraph D, your coverage will begin at 12:01 a.m. on the date of the loss of coverage or eligibility for state premium assistance. If you enroll for coverage pursuant to Subparagraph C above, your coverage will begin at 12:01 a.m. on: the date of the birth, adoption, guardianship or placement for adoption; or of marriage or commencement of a domestic partnership.

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

A. **To Add a Spouse, Domestic Partner or Child.** If you need to add a spouse, domestic partner or child to your coverage (other than a newborn child added under paragraph 2 or 3 above), you must complete and return to the Group a form for this purpose and any requested documentation. The addition of a spouse, domestic partner or child will be effective as of the date of marriage, commencement of domestic partnership or the adoption or other event making the child eligible for coverage under paragraph 1, if you return to the Group a completed application and requested documents within 30 days of the marriage, commencement of domestic partnership, or the adoption or other event, and the applicable contribution is paid. If you do not return a completed form and documentation within the 30-day period described above, your spouse, domestic partner, or child will be added to your coverage after the next open enrollment period, so long as the applicable contribution is paid.

B. **When Coverage of a Spouse, Domestic Partner, or Child Terminates.** If you have other than individual coverage, you should notify the Group of any event that affects your coverage, such as: your divorce, termination of a domestic partnership, the death of your spouse or domestic partner, or Medicare eligibility; or a child reaching the age at which coverage terminates or otherwise experiencing an event that would normally result in termination of the child's coverage. The Group will provide you with a form for that purpose. If such change results in you seeking a different type of coverage at a lower rate (such as a switch to individual coverage), the form and requested documentation must be returned within 30 days of the event in order for the change to be effective on the date of the event. If you do not return a completed form and any requested documentation within 30 days of the event, the change in premium will be effective as of the next premium due date after they are received. Nothing in this Subparagraph B is designed to affect the provisions of Section Seventeen

governing terminations of coverage. This Subparagraph B only involves the effective date of changes in premium due to terminations of coverage under Section Seventeen.

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

SECTION THREE - MEDICAL NECESSITY AND PRIOR APPROVAL

1. **Medical Necessity.** Coverage will be provided under the Benefit Plan as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "Service") is Medically Necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that the Benefit Plan has to provide coverage for it.
The Benefit Plan may base its decision on a review of:
   (1) Your medical records;
   (2) Medical policies and clinical guidelines;
   (3) Medical opinions of a professional society, peer review committee or other groups of physicians;
   (4) Reports in peer-reviewed medical literature;
   (5) Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
   (6) Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment;
   (7) The opinion of Professional Providers in the generally recognized health specialty involved;
   (8) The opinion of the attending providers, which have credence but do not overrule contrary opinions.

   Services will be deemed Medically Necessary only if:
   (1) They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
   (2) They are required for the direct care and treatment or management of that condition;
   (3) Your condition would be adversely affected if the services were not provided;
   (4) They are provided in accordance with generally accepted standards of medical practice;
   (5) They are not primarily for the convenience of you, your family, or your provider;
   (6) They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
   (7) When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, the Benefit Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a physician's office or the home setting.

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

rehabilitative for the covered Service described in this Benefit Plan, as long as the Service is Medically Necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the Service does not make it Medically Necessary or mean that the coverage has to be provided for the Service under the Benefit Plan.

3. **Services subject to Preauthorization.** Preauthorization is required before you receive certain services covered under this Benefit Plan. The services subject to preauthorization are:

   (a) All inpatient stays, excluding maternity stays for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section.
   (b) All services relating to organ and tissue transplants.
   (c) Home care.
   (d) Durable Medical Equipment, including assistive communication devices, in excess of $200.
   (e) The following advanced imaging services: MRI, CAT, and PET scans.

4. **Preauthorization Procedure.** If you seek coverage for the Services listed in paragraph 3 above, you must call the Claims Administrator at the number indicated on your ID card to have the care pre-approved. It is requested that you call at least seven days prior to a planned inpatient admission.

   If you are hospitalized in cases of an Emergency Condition involving any of these services, you should call within 24 hours after your admission or as soon thereafter as reasonably possible. However, you must call as soon as it is reasonably possible in order for any follow-up care to be covered without the reduction described in paragraph 6 below. The availability of an organ for transplantation resulting in the necessity for an immediate admission for implantation shall be considered an Emergency Condition for purposes of this paragraph.

   After receiving a request for preauthorization, the Claims Administrator will review the reasons for your planned treatment and determine if benefits are available. The Claims Administrator will notify you and your Professional Provider of the decision by telephone and in writing within three business days of receipt of all necessary information. If your treatment involves continued or extended health care services, or additional services for a course of continued treatment, the Claims Administrator will notify you and your Professional Provider within one business day of receipt of all necessary information.

5. **Your Right to Appeal.** If you or your Professional Provider disagrees with the Claims Administrator's decision, you may appeal by following the procedures set forth in the General Provisions section of this Benefit Plan.

6. **Failure to Seek Preauthorization.** If you fail to seek preauthorization for Services listed in paragraph (3) above, other than with respect to Services received due to an Emergency Condition, the Benefit Plan will pay the lesser of (A) $500 less than what

would otherwise have been paid for the Services or (B) 50% of the amount that would otherwise have been paid for the Services. You must pay the remaining charges and such charges will not count towards your Out-of-Pocket Limit. The Benefit Plan will pay the amount specified above only if it is determined that the care was Medically Necessary. If it is determined that the care, services or treatment were not Medically Necessary, you will be responsible for paying the entire charge for the Services and such charges will not count towards your Out-of-Pocket Limit.

7. **Utilization Review.** The Benefit Plan reviews health services to determine whether the services are or were Medically Necessary or experimental or investigational. This process is called utilization review. Utilization review includes all review activities, whether they take place prior to the Service being performed (Preauthorization); 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 ID 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 or are experimental or investigational will be made by: 1) licensed physicians; or 2) licensed, certified, registered or credentialed Professional Providers 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 mental health or substance use disorder treatment, licensed physicians or licensed, certified, registered or credentialed Professional Providers who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment.

   The Benefit Plan has specific guidelines and protocols to assist in this process. It will use evidence-based and peer reviewed clinical review criteria 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 www.excellusbcbs.com.

   You may request that the Benefit Plan send you electronic notification of a utilization review determination instead of notice in writing or by telephone. You must tell the Benefit Plan in advance if you want to receive electronic notifications. To opt into electronic notifications, call the number on your ID card or visit www.excellusbcbs.com. You can opt out of electronic notifications at any time.

8. **Medical Management.** The benefits available to you under the Benefit Plan are subject to pre-service (Preauthorization), concurrent and retrospective reviews to determine when services should be covered. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. In addition, any benefits available to you are subject to medical policies, administrative policies or billing policies

of the Benefit Plan. Services must be Medically Necessary for benefits to be covered under the Benefit Plan.

SECTION FOUR - COST-SHARING EXPENSES

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

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

   B. Your Coinsurance for Out-of-Network Benefits is 30%.

2. **Copayments.** You must pay a Copayment for certain services covered under the Benefit Plan. The specific Copayment that applies is contained in the section of this booklet that describes that particular service.

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

   A. If you have individual coverage you must pay the first $250 of Allowable Expenses incurred under the Benefit Plan during each Calendar Year for In-Network Benefits and Out-of-Network Benefits.

   B. If you have family coverage, the Deductible applies to each person covered under the Benefit Plan. However, after Deductible payments for any and all persons covered under the Benefit Plan total $750 of Allowable Expense in a Calendar Year for In-Network Benefits and Out-of-Network Benefits, no further Deductible will be required for any person covered under the Benefit Plan for that Calendar Year.

   C. In addition to the above, there is also a separate $50 Deductible for in-network and out-of-network home care visits and home infusion therapy. This separate Deductible applies to each person in a family and counts towards satisfaction of the $250 individual or $750 family Deductible described above.

   If you have family coverage, each person within a family must satisfy the individual Deductible listed above before any expenses (unless otherwise stated elsewhere in this booklet) will be covered by the Benefit Plan for that person in the Calendar Year; however, any combination of family members may satisfy the full family Deductible. Once the family Deductible is met by one or more people within the family, the Benefit Plan will begin to pay for coverage for any individual within the family.

   If you use a combination of In-Network Providers (including In-Network Pharmacies) and Out-of-Network Providers, your total Deductible amount required to be paid will never exceed the Deductible amount shown above for Out-of-Network Providers. This means that the Deductible amount you pay for Out-of-Network Providers (including In-Network Pharmacies) and Out-of-Network Providers is combined. Any amounts you pay towards satisfaction of the In-Network Provider Deductible will count towards satisfaction of the

Out-of-Network Provider Deductible and any amounts you pay towards satisfaction of the Out-of-Network Provider Deductible will also count towards satisfaction of the In-Network Provider Deductible.

4. **Out-of-Pocket Limit**. When you have expended a certain amount for in-network or out-of-network Coinsurance, Copayments (including Prescription Drug Copayments) and Deductibles (including the separate home care visit Deductible) in a Calendar Year, the Benefit Plan will provide coverage for 100% of the Allowable Expense for In-Network Benefits and Out-of-Network Benefits covered under the Benefit Plan for the remainder of that Calendar Year.

   A. If you have individual coverage, the total Out-of-Pocket Limit is $1,000 for In-Network Benefits and Out-of-Network Benefits.

   B. If you have family coverage, the total Out-of-Pocket Limit is $3,000 for In-Network Benefits and Out-of-Network Benefits.

   If you have family coverage, once a person within a family has paid $1,000 for In-Network Benefits and Out-of-Network Benefits in Coinsurance, Copayments, and Deductibles in a Calendar Year, the Benefit Plan will provide coverage for 100% of the Allowable Expense for the rest of that Calendar Year for that person.

   If you use a combination of In-Network Providers (including In-Network Pharmacies) and Out-of-Network Providers, your Out-of-Pocket Limits are separate amounts and are not combined. This means that you will be required to satisfy the Out-of-Pocket Limit amount for In-Network Providers (including In-Network Pharmacies) and Out-of-Network Providers separately. The amounts you pay towards satisfaction of the In-Network Provider Out-of-Pocket Limit do not count towards satisfaction of the Out-of-Network Provider Out-of-Pocket Limit and the amounts you pay towards satisfaction of the Out-of-Network Provider Out-of-Pocket Limit do not count towards satisfaction of the In-Network Provider Out-of-Pocket Limit. Any charges of an Out-of-Network Provider that are in excess of the Allowable Expense will remain your responsibility.

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

   When you receive covered services from an Out-of-Network Provider, the Claims Administrator will apply nationally recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services you received. Sometimes, applying these rules will change the way that the Claims Administrator pays for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. As an example, your provider may have billed using

several procedure codes when there is a single code that includes all of the separate procedures. The Claims Administrator will make one inclusive payment in that case, rather than a separate payment for each billed code. Another example of when the payment rules will be applied to a claim is when you have surgery that involves two surgeons acting as "co-surgeons". Under the payment rules, the claim from each provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If the Claims Administrator receives a claim that does not have the correct modifier, the Claims Administrator will change it and make the appropriate payment.

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

SECTION FIVE – ACCESS TO CARE AND TRANSITIONAL CARE

Access to Care.
If the Benefit Plan does not have an In-Network Provider that has the appropriate training and experience to treat your condition, the Benefit Plan will approve an authorization to an appropriate Out-of-Network Provider. Your In-Network Provider or you must request prior approval from the Claims Administrator of the authorization to a specific Out-of-Network Provider. Approvals of authorizations to Out-of-Network Providers will not be made for the convenience of you or another treating provider and may not necessarily be to the specific Out-of-Network Provider you requested. If the Benefit Plan approves the authorization, all services performed by the Out-of-Network Provider are subject to a treatment plan approved by the Benefit Plan in consultation with your primary care physician, the Out-of-Network Provider and you. Covered services rendered by the Out-of-Network Provider will be covered as if they were provided by an In-Network Provider. You will be responsible only for any applicable In-Network Provider Cost-Sharing. In the event an authorization is not approved, any services rendered by an Out-of-Network Provider will be covered at the Out-of-Network Provider benefit level, if available.

Transitional Care.
If you are in an ongoing course of treatment when your In-Network Provider leaves the network then you may continue to receive covered services for the ongoing treatment from the former In-Network Provider for up to 90 days from the date your provider's contractual obligation to provide services to you under the Benefit Plan terminates. If you are pregnant, you may continue care with a former In-Network Provider through delivery and any postpartum care directly related to the delivery.

The provider must accept as payment the negotiated fee that was in effect just prior to the termination of the relationship of the provider with the network. The provider must also provide the Benefit Plan with necessary medical information related to your care and adhere to any policies and procedures established by the Benefit Plan, including those for assuring quality of care and obtaining preauthorization and a treatment plan approved by the Benefit Plan. You will receive covered services as if they were being provided by an In-Network Provider. You will be responsible only for any applicable Cost-Sharing.

In addition to the above, if you are considered a "continuing care patient" and any benefits under the Benefit Plan are terminated because of a change in the terms of participation of your provider in the network, you will be given notice of such change or termination and will have the right to elect to continue coverage under the Benefit Plan, with respect to that provider, under the same terms and conditions that were in effect on the date you are given notice of the provider's change in network status or termination of benefits as a results of a change in network participation. If you elect to continue such coverage under the Benefit Plan, coverage for transitional care with respect to that provider will be provided under those same terms and conditions only for the period ending on the earlier of (1) 90 days from the date the notice is provided or (2) the date you are no longer considered a "continuing care patient". In addition, coverage under those same terms and conditions during this period of transitional care is limited

to the condition for which you were receiving care from your provider, that qualifies you as a "continuing care patient", prior to the provider's change in network status.

For purposes of this section, you are a "continuing care patient" if you meet any of the following conditions:

(1) You are undergoing a course of treatment for a serious and complex condition. Serious and complex condition means:
    a. An acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
    b. A chronic illness that is life threatening, degenerative, potentially disabling or congenital and requires specialized medical care for a prolonged period of time.
(2) Undergoing a course of institutional or inpatient care from the provider.
(3) You are scheduled to undergo non-elective surgery, including post-operative care from the provider.
(4) You are pregnant and undergoing a course of treatment for the pregnancy from the provider.
(5) You are terminally ill (as defined in Section 1861 of the Social Security Act) and receiving treatment for the terminal illness from the provider

Please note, if the provider was terminated by the network due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the provider's ability to practice, continued treatment with that provider is not available.

If you have any questions with respect to this Transitional Care provision, please contact your Plan Administrator or the Claims Administrator at the telephone number listed on your identification card.

SECTION SIX – PROTECTION FROM SURPRISE BILLS

A surprise bill is a bill you receive for covered services in the following circumstances:

(1) Emergency Services performed by an Out-of-Network Provider with respect to an Emergency Condition;
(2) Air ambulance services performed by an Out-of-Network Provider; and
(3) For certain non-Emergency Services performed by an Out-of-Network Provider at a participating Hospital, Ambulatory Surgical Center and Independent Free Standing Emergency Department .

There are special reimbursement rules that apply to surprise bills when determining the Benefit Plan's payment to the Out-of-Network Provider. These special reimbursement rules will always apply to the following covered non-Emergency Services when performed by an Out-of-Network Provider at a participating Hospital, Ambulatory Surgical Center and Independent Free Standing Emergency Department:

(1) Covered services performed by an Out-of-Network Provider when an In-Network Provider is unavailable at the time the health care services are performed at the participating Hospital, Ambulatory Surgical Center and Independent Free Standing Emergency Department;
(2) Covered services performed by an Out-of-Network Provider as a result of unforeseen, urgent medical issues that arise at the time such services are performed, even if you previously consented to the Out-of-Network Provider performing such services;
(3) Covered services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
(4) Covered services provided by assistant surgeons, hospitalists and intensivists; and
(5) Diagnostic services, including radiology and laboratory services.

A surprise bill does not include a bill for health care services when In-Network Provider is available and you elected to receive services from an Out-of-Network Provider or, with respect to non-Emergency Services (other than those specified above) performed by an Out-of-Network Provider in a participating Hospital, Ambulatory Surgical Center and Independent Free Standing Emergency Department if the Out-of-Network Provider has obtained your consent to receive the services after providing you with required notice and satisfying all other consent requirements applicable to the Out-of-Network Provider. If the Out-of-Network Provider follows the notice and consent requirements and you consent to receiving the services, the Benefit Plan's normal reimbursement rules with respect to Out-of-Network Provider's will apply with regard to those services and you may be Balance Billed. Please see the definition of Allowable Expense with respect to the Benefit Plan's normal reimbursement rules.

For any surprise bills, the Benefit Plan will reimburse the Out-of-Network Provider an initial payment equal to the Recognized Amount. You will be held harmless for any Out-of-Network Provider charges for the surprise bill that exceed your Cost-Sharing (i.e. Copayment, Deductible or Coinsurance) for In-Network Providers. Your Cost-Sharing will be calculated based off of the

Recognized Amount and will count towards your in-network Provider Deductible, if any, and your in-network Out-of-Pocket Limit.

For purposes of this section, the Recognized Amount means the lesser of billed charges or the "qualifying payment amount." The "qualifying payment amount" is the amount determined by the Benefit Plan in accordance with the requirements of 29 CFR 2590.716-3.

The provisions specified in this section and elsewhere in this amendment/SMM are designed to comply with the group health plan requirements of the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021 (the "No Surprises Act"). The provisions are based on regulations published by the U.S. Department of the Treasury, Department of Labor, and Department of Health and Human Services (the "Departments") and will be interpreted to be consistent with those regulations. If the Departments issue additional guidance regarding the requirements of the No Surprises Act, the Benefit Plan will comply with the additional or modified requirements as required by such guidance.

SECTION SEVEN - INPATIENT CARE

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

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

   A. Additional charges for special duty nurses;

   B. Private room, unless the Claims Administrator determines that it is Medically Necessary for you to occupy a private room or the Facility has no semi-private rooms. If you occupy a private room in a Facility, and the Claims Administrator determines that a private room is not Medically Necessary and that the Facility has semi-private rooms, the Benefit Plan's coverage will be based upon the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room;

   C. Medications, supplies and equipment that you take home from the Facility;

   D. Custodial care (see Section Fourteen); or

   E. Radio, telephone and television expenses, or beauty and barber services.

3. **Conditions for Inpatient Care.** Inpatient Facility care is subject to the following conditions and limitations:

   A. **Inpatient Hospital Care.** The Benefit Plan will provide coverage when you are required to stay in a Hospital for acute medical or surgical care. The Benefit Plan will provide coverage for any day on which it is Medically Necessary for you to receive inpatient care.

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

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

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

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

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

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

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

D. **Skilled Nursing Facility.** The Benefit Plan will provide coverage for care in a Skilled Nursing Facility if it is determined that hospitalization would otherwise be Medically Necessary for the care of your condition, illness or injury for up to 120 days in a Calendar Year.

In-Network Benefits and Out-of-Network Benefits for a Skilled Nursing Facility will both be counted toward the 120-day per year limit described above.

E. **Physical Rehabilitation.** The Benefit Plan will provide coverage for comprehensive physical medicine and rehabilitation (chemical dependence and abuse programs are excluded) for up to 60 days per Calendar Year for a condition that in the judgment of your Professional Provider and the Medical Director can reasonably be expected to result in significant improvement within a relatively short period of time.

In-Network Benefits and Out-of-Network Benefits for physical rehabilitation will both be counted toward the 60-day limited described above.

4. **Maternity Care and Newborn Care.** The Benefit Plan will provide coverage for inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. The Benefit Plan will also provide coverage for any additional days of such care that the Claims Administrator determines are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum coverage period, the Benefit Plan will provide coverage of the home care visit furnished by the type of home care agency described in Section Seven of this booklet. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later.

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

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

7. **Internal Prosthetic Devices.** The Benefit Plan's coverage for inpatient Hospital care includes coverage for internal prostheses that are surgically implanted and Medically Necessary for anatomical repair or reconstructive purposes. Internal prosthetic devices are designed to replace all or part of a permanently inoperative, absent or malfunctioning body organ. Examples of internal prosthetic devices include: cardiac pacemakers, implanted cataract lenses and surgically implanted hardware necessary for joint repair or reconstruction.

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

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

10. **Benefits for Inpatient Care.**

    In-Network. In-Network Benefits, other than for physical rehabilitation and routine newborn nursery, are covered at 80% of the Allowable Expense, after Deductible. In-Network Benefits for physical rehabilitation are covered at 100% of the Allowable Expense. In-Network Benefits for routine newborn nursery care are covered at 80% of the Allowable Expense.

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

SECTION EIGHT - OUTPATIENT CARE

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

1. **Care in Connection with Surgery.** The Benefit Plan will only provide coverage if the Claims Administrator determines that it was Medically Necessary to use the Facility to perform the surgery.

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

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

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

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

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

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

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

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

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

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

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

4. **Laboratory and Pathology Services.** The Benefit Plan provides coverage for routine laboratory procedures and diagnostic testing, services and materials, including fluoroscopy, electrocardiograms, electroencephalograms, and laboratory tests.

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

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

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

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

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

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

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

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

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

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

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

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

(A) One (1) baseline screening mammogram for Members age 35 through 39; and

(B) One (1) screening mammogram annually for Members age 40 and over.

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

Members provider.

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

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

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

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

9. **Cervical Cytology Screenings (Pap Smears).** The Benefit Plan will provide coverage for screening for cervical cancer and its precursor states for women 18 years of age or older, or for younger women who are sexually active, according to the Claims Administrator's preventive care guidelines. The screening may be provided in the outpatient department of a Facility under this section or in a Professional Provider's office pursuant to Section Nine. The Benefit Plan will provide coverage for one (1) screening each Calendar Year (In-Network Benefits and Out-of-Network Benefits combined) for women age 18 and older under this section and Section Nine. Cervical cytology screening shall mean a pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

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

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

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

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

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

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

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

11. **Pulmonary Rehabilitation.** The Benefit Plan will provide coverage for Medically Necessary patient assessment and formal training and education phases of pulmonary rehabilitation programs. Services must be rendered by an approved pulmonary rehabilitation program provider and recommended by the Member's cardiologist or Professional Provider.

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

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

12. **Cardiac Rehabilitation.** The Benefit Plan will provide coverage for Medically Necessary Phase I and Phase II cardiac rehabilitation programs. Services must be rendered by an approved cardiac rehabilitation program provider and recommended by the Member's cardiologist or Professional Provider.

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

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

13. **Colonoscopy.** The Benefit Plan provides coverage for colonoscopies to screen for colon cancer in an asymptomatic Member in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from the USPSTF.

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

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

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

14. **Mental Health Disorder Outpatient Services.** The Benefit Plan covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of Mental Health Disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; a licensed marriage and family therapist; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator.

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

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

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

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

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

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

16. **Infertility Services.** The Benefit Plan will provide coverage for outpatient Facility care in connection with the diagnosis and treatment of infertility provided by a Professional Provider pursuant to Section Nine.

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

SECTION NINE - HOME CARE

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

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

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

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

   B. You apply to the home care provider through your Professional Provider with supporting evidence of your need and eligibility for the care; and

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

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

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

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

   B. Part-time or intermittent home health aide services, that consist primarily of direct care rendered to you;

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

   D. Medical supplies, drugs and medications prescribed by your physician, laboratory services, durable medical equipment and infusion therapy, when provided by or on behalf of the home health agency or home care services agency, but only to the extent such items would have been covered under the Benefit Plan if you were a patient in a Hospital or Skilled Nursing Facility.

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

4. **Failure to Comply with Treatment Plan.** If you fail or are unable to comply with the home care treatment plan, the Benefit Plan will terminate benefits for that plan of care.

5. **Benefits for Home Care.**

In-Network. In-Network Benefits are covered at 80% of the Allowable Expense, after a $50 Deductible.

Out-of-Network. Out-of-Network Benefits are covered at 75% of the Allowable Expense, after a $50 Deductible.

SECTION TEN - HOSPICE CARE

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

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

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

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

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

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

   B. Day care services provided by the hospice organization;

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

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

      (2) Physical therapy;

      (3) Speech therapy;

      (4) Occupational therapy;

      (5) Respiratory therapy;

      (6) Social services;

      (7) Nutritional services;

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

(9) Medical supplies;

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

(11) Durable medical equipment; and

(12) Bereavement services provided to the terminally ill patient's family during illness, and until one year after death.

D. Medical care provided by a physician.

4. **Number of Days.** The Benefit Plan will provide coverage for up to five visits for bereavement counseling services per Calendar Year.

In-Network Providers and Out-of-Network Providers count toward the five visit limit described above.

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

6. **Benefits for Hospice Care.**

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

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

SECTION ELEVEN - PROFESSIONAL SERVICES

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

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

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

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

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

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

   B. **Outpatient Surgery.** The Benefit Plan will provide coverage for surgical procedures performed in the outpatient department of a Hospital or other Facility or in a Hospital-based or freestanding ambulatory surgery facility.

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

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

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

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

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

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

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

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

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

(2) **Through Different Incisions.** If covered multiple surgical procedures are performed during the same operative session but through different incisions, the Benefit Plan will provide the following benefits:

(a) The benefit described above for the primary procedure; plus

(b) 50% of the amount otherwise payable for all other procedures.

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

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

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

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

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

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

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

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

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

A. You seek the second or third surgical opinion after your surgeon determines your need for surgery.

B. The second or third surgical opinion is rendered by a physician:

(1) Who is a board certified specialist; and

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

C. The second or third surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under the Benefit Plan if such surgery was performed.

D. You are examined in person by the physician rendering the second or third surgical opinion.

E. The specialist who renders the opinion does not also perform the surgery.

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

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

5. **Second Medical Opinions.** The Benefit Plan will provide coverage for an office visit in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer. A positive diagnosis of cancer occurs when you are diagnosed by your Professional Provider as having some form of cancer. A negative diagnosis of cancer occurs when your Professional Provider performs a cancer-screening exam on you and finds that you do not have cancer, based on the exam results. The Benefit Plan will also provide coverage for a second medical opinion concerning any recommendation of a course of treatment of cancer. The second medical opinion must be rendered by an appropriate specialist, including but not limited to, a specialist associated with a specialty care center for the treatment of cancer. You will be entitled to In-Network Benefits when your Professional Provider provides a written referral to an Out-of-Network Professional Provider.

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

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

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

A. **Normal Pregnancy.** Maternity care includes the first visit upon which a positive pregnancy test is determined. It also includes all subsequent prenatal and postpartum care. These benefits include the services of a licensed midwife, practicing consistent with section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed under the New York Public Health Law or comparable law of another state.

In-Network. In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible. For maternity care that is considered preventive in accordance with the preventive services provision of the Benefit Plan (Section Ten) In-Network Benefits are covered at 100% of the Allowable Expense.

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

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

In-Network. In-Network Benefits, other than for Medically Necessary terminations of pregnancy, are covered at 80% of the Allowable Expense,

after Deductible. In-Network Benefits for Medically Necessary terminations of pregnancy are covered at 100% of the Allowable Expense.

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

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

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

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

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

The Professional Provider's services must be documented in the Facility records. The Benefit Plan will cover only one visit per day per Professional Provider. However, services rendered by up to two Professional Providers on a single day will be covered if the two Professional Providers have different specialties and are treating separate conditions.

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

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

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

A. **Preventive Health Services.** The Benefit Plan will provide coverage for the following health prevention programs rendered in the Professional Provider's office or by other providers designated by the Medical Director:

(1) **Routine Physical Examinations.** The Benefit Plan will provide coverage for one adult routine physical examination per Member, per Calendar Year.

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

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

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

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

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

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

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

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

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

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

B. **Other Health Services.**

(1) **Laboratory and Pathology Services.** The Benefit Plan provides coverage for routine laboratory procedures and diagnostic testing, services and materials, including fluoroscopy, electrocardiograms, electroencephalograms, and laboratory tests.

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

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

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

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

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

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

(a) **Routine Hearing Examinations.** Routine hearing examinations are limited to one exam per Calendar Year.

In-Network Benefits and Out-of-Network Benefits will both be counted toward the annual exam maximum.

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

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

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

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

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

(4) **Hearing Aids.** The Benefit Plan will provide coverage for one pair of hearing aids that are Medically Necessary for Members every five (5) Calendar Years:

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

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

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

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

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

D. **Office Consultations.** The Benefit Plan will provide coverage for consultations billed by a physician. A consultation is professional advice given by a physician to your attending physician upon request of your attending physician.

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

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

9. **Telehealth/Telemedicine.** The Benefit Plan will provide coverage for any services delivered by a provider using telehealth/telemedicine ("Telehealth"). Covered services delivered using Telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of Benefit Plan 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 (e.g. telephone consultations, e-mail consultations, online internet consultations, etc.) by a provider to deliver covered services to a Member while that person's location is different than the provider's location. Telehealth may be provided by any provider that chooses to use Telehealth.
Coverage will also be provided for Telehealth between a Member and providers that participate with MDLive. Not all In-Network Providers participate with MDLive. For a listing of providers that participate with MDLive, Members may check the participating provider directory by visiting www.mdlive.com or by contacting MDLive, toll free, at 866-692-5045.

Telehealth allows a Member to connect with a provider via video conference, telephone or e-mail for the purposes of diagnosis, consultation and treatment; just as would be provided during a face to face office visit. If your provider utilizes Telehealth he/she will provide you with instructions on how to access that service. Telehealth, through MDLive; however, is an optional service provided under the Benefit Plan. To utilize this service, Members must register by calling MDLive, toll free at 866-692-5045, or by visiting www.mdlive.com. MDLive will ask for the Member's name, the patient's name (if not calling for yourself), the primary Member's and patient's date of birth and zip code.

Common examples of when to use Telehealth, include, but are not limited to the following:

(1) The Member's primary care doctor is not available.

(2) The Member's is traveling and in need of medical care.

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

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

******Telehealth should only be used for non-emergent situations. If you feel you are in an urgent or life-threatening situation and need immediate assistance, please go to the nearest emergency room******

If you have questions concerning Telehealth or the MDLive program, the available care or coverage, or your benefits, please contact the customer service telephone number on your identification care or MDLive at the telephone number or internet address listed above. In the unlikely event that the Telehealth provider or MDLive is unable to resolve your inquiry, you may, as with any medical service, follow the claim and appeal process that is described in the claim and appeals procedures section of this Booklet.

In-Network. In-Network Benefits, other than through MDLive, are subject to the same Coinsurance, Copayment, or Deductible as similar services. In-Network Benefits through MDLive are subject to a $10 Copayment.

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Out-of-Network. Out-of-Network Benefits, other than through MDLive, are subject to the same Coinsurance, Copayment, or Deductible as similar services. Out-of-Network Benefits through MDLive are not covered under the Benefit Plan.

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

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

the installation of the equipment where you receive the service has been approved under that procedure.

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

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

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

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

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

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

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

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

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

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

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

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

(A) One (1) baseline screening mammogram for Members age 35 through 39; and

(B) One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, the Benefit Plan covers mammograms as recommended by the Members provider.
Diagnostic mammograms (mammograms that are performed in connection with the

diagnosis of breast cancer) are covered whenever they are Medically Necessary.

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

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

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

15. **Gynecological Services.** The Benefit Plan will provide coverage for gynecology visits, including coverage for screening for cervical cancer and its precursor states for women 18 years of age and older, or for younger women who are sexually active, according to the Claims Administrator's preventive care guidelines. The screening may be provided in the outpatient department of a Facility pursuant to Section Six or in a Professional Provider's office pursuant to this section. The Benefit Plan will provide coverage for one (1) screening each Calendar Year (In-Network Benefits and Out-of-Network Benefits combined) for women age 18 and older under this section and Section Six. Cervical cytology screening shall mean an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

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

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

16. **Screenings for Prostate Cancer.** The Benefit Plan will provide coverage for diagnostic screenings for prostate cancer, including standard diagnostic testing and standard diagnostic exams, according to the Claims Administrator's preventive care guidelines. At a minimum, the Benefit Plan will provide coverage for prostate screenings as follows:

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

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

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

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

Diagnostic prostate cancer screenings are also covered whenever they are Medically Necessary.

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

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

17. **Colonoscopy.** The Benefit Plan provides coverage for colonoscopies to screen for colon cancer in an asymptomatic Member in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from the USPSTF.

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

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

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

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

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

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

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

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

B. Determined to be Medically Necessary.

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

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

20. **Inpatient Consultations.** The Benefit Plan will provide coverage for consultations billed by a physician subject to the limitations below. A consultation is professional advice given by a physician to your attending physician upon request of your attending physician.

A. The physician who is called in is a specialist in your illness or disease;

B. The consultations take place while you are a registered bed patient in a Facility;

C. The consultation is not required by the rules or regulations of the Facility;

D. The consulting physician does not thereafter render care or treatment to you;

E. The consulting physician enters a written report in your Facility records; and

F. Payment will be made for only one consultation during any one day unless a separate diagnosis exists.

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

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

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

A. **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. Infertility is determined in accordance with the standards and guidelines established and

adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine. Basic infertility services include:

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

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

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

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

C. **Advanced Infertility Services.** The Benefit Plan covers the following advanced infertility services:

I. Lifetime Maximum of three (3) cycles of in vitro fertilization; and
II. Cryopreservation and storage of sperm, ova, and embryos in connection with in vitro fertilization.

A "cycle" is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

D. **Fertility Preservation Services.** The Benefit Plan covers standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Iatrogenic infertility"

means an impairment of your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes

E. **Deductibles and Copayments.** The benefits of this paragraph are subject to any applicable Deductible, Coinsurance or Copayment provisions under this section for similar services.

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

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

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

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

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

E. With such age, gender and/or physiological characteristics that pose a significant risk of osteoporosis.

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

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

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

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

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

24. **Mental Health Disorder Outpatient Services.** The Benefit Plan covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of Mental Health Disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; a licensed marriage and family therapist; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator.

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

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

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

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

amount, regardless of the number of family members who attend the family therapy session.

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

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

SECTION TWELVE - ADDITIONAL BENEFITS

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

   A. **Screening and Diagnosis.** Coverage will be provided for assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

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

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

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

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

D. **Psychiatric and Psychological Care.** Coverage will be provided for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.

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

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

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

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

2. **Treatment of Diabetes.** The Benefit Plan will provide coverage for the following equipment and supplies for the treatment of diabetes that the Claims Administrator determines to be Medically Necessary and when prescribed or recommended by your Professional Provider or other In-Network medical personnel legally authorized to prescribe under Title 8 of the New York State Education Law ("Authorized Medical Personnel"):

A. Insulin and oral agents for controlling blood sugar;

B. Blood glucose monitors;

C. Blood glucose monitors for the visually impaired;

D. Data management systems;

E. Test strips for glucose monitors, visual reading and urine testing;

F. Injection aids;

G. Cartridges for the visually impaired;

H. Insulin pumps and appurtenances thereto;

I. Insulin infusion devices; and

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

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

The Benefit Plan will also pay for disposable syringes and needles used solely for the injection of insulin. The Benefit Plan will not pay for reusable syringes and needles or multi-use disposable syringes or needles. The Benefit Plan will pay for diabetes self-management education and diet information provided by your Professional Provider or Authorized Medical Personnel, or their staff, in connection with Medically Necessary visits upon the diagnosis of diabetes, a significant change in your symptoms, the onset of a condition necessitating changes in self-management or where re-education or refresher education is Medically Necessary, as determined by the Claims Administrator. When such education is provided as part of the same office visit for diagnosis or treatment of diabetes, payment for the office visit shall include payment for the education. The Benefit Plan will also pay for home visits, when Medically Necessary.

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

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

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

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

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

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

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

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

E. **COVID-19 Vaccine:** Effective as of 15 business days after a recommendation is made from the United States Preventive Services Task Force or CDC Advisory Committee on Immunization Practices, the Benefit Plan will provide coverage for vaccines and other services intended to prevent COVID-19. Effective on or after May 12, 2023, the Benefit Plan will continue to provide coverage for the COVID-19 vaccine in accordance with the recommendation made by the U.S. Preventive Services Task Force or CDC Advisory Committee on Immunization Practices. Such coverage will be provided without Cost-Sharing (i.e. Coinsurance, Copayment, Deductible) when rendered by an In-Network Provider. When coverage is rendered by an Out-of-Network Provider, it will be subject to the same Cost-Sharing that is applicable to adult immunizations or well child immunizations rendered by an Out-of-Network Provider.

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

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

to the office visit will still apply.

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

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

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

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

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

B. **External Prosthetic Devices.** The Benefit Plan will provide coverage for external prosthetic devices necessary to relieve or correct a condition caused by an injury or illness. The Benefit Plan will cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Your physician must order the prosthetic device for your condition before its purchase. Although the Claims Administrator requires that a physician prescribe

the device, this does not mean that the Claims Administrator will automatically determine you need it. The Claims Administrator will determine if the prosthetic device is Medically Necessary. The Benefit Plan will only provide benefits for a prosthetic device that the Claims Administrator determines can adequately meet the needs of your condition at the least cost.

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

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

C. **Orthotic Devices.** The Benefit Plan will provide coverage for orthotic devices that are rigid or semi-rigid (having molded plastic or metal stays) when the devices are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness. Orthotic devices include orthopedic braces and custom-built supports, including foot orthotics. The Benefit Plan will cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Your physician must order the orthotic device for your condition before its purchase. Although the Claims Administrator requires that a physician prescribe the device, this does not mean that the Claims Administrator will automatically determine you need it. The Claims Administrator will determine if the orthotic device is Medically Necessary. The Benefit Plan will only provide benefits for an orthotic device that the Claims Administrator determines can adequately meet the needs of your condition at the least cost. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

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

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

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

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

5. **Pre-hospital Emergency Services and Transportation.** The Benefit Plan will provide coverage for services to evaluate and treat an Emergency Condition when such services are provided by an ambulance service certified under the Public Health Law. The Benefit Plan will also provide coverage for land or air ambulance transportation to a Hospital by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

A. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

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

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

D. Serious disfigurement of such person.

In-Network. In-Network Benefits, other than for air ambulance, are subject to a $50 Copayment. In-Network Benefits for air ambulance are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network. Out-of-Network Benefits, other than for air ambulance, are subject to a $50 Copayment. Out-of-Network Benefits for air ambulance are covered at 70% of the Allowable Expense, after Deductible.

6. **Ambulance Service.** In addition to the services described in paragraph 5 above, the Benefit Plan will also provide coverage for the following Medically Necessary services provided by a certified ambulance service:

A. Ground, water or air ambulance service for an urgent condition to the nearest Hospital where Emergency Services can be performed. When you have an urgent condition, the need for care is less than the need for care of an Emergency Condition, but the condition requires immediate attention. An urgent condition is one that may become an Emergency Condition in the absence of treatment.

B. Ground, water or air transportation between Facilities when the transport is any of the following:

i From an Out-of-Network Provider Hospital to an In-Network Provider Hospital;
ii To a Hospital that provides a higher level of care that was not available at the original Hospital;
iii To a more cost effective Acute care Facility; or
iv From an Acute care Facility to a sub-Acute setting.

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

C. **Limitations.**

i The Benefit Plan does not cover non-ambulance transportation such as ambulette, van or taxi cab.
ii Coverage for air ambulance related to an Emergency Condition or air ambulance related to a non-Emergency Condition is provided to the nearest Facility, as described in (B) above, when your medical condition is such that transportation by land ambulance is not appropriate; and your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
    1. The point of pick-up is inaccessible by land vehicle; or
    2. Great distances or other obstacles (e.g., heavy traffic) prevent your timely transfer to the nearest Hospital with appropriate facilities.

In-Network. In-Network Benefits, other than for air ambulance, are subject to a $50 Copayment. In-Network Benefits for air ambulance are covered at 80% of the Allowable Expense, after Deductible.

Out-of-Network. Out-of-Network Benefits, other than for air ambulance, are subject to a $50 Copayment. Out-of-Network Benefits for air ambulance are covered at 70% of the Allowable Expense, after Deductible.

7. **Care in a Freestanding Urgent Care Center.** The Benefit Plan will provide coverage

for care at a freestanding urgent care center to treat your illness or condition. Urgent care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require care from an emergency room department. If you need care after normal business hours, including evenings, weekends or holidays, you have options. You can call your Professional Provider's office for instructions or visit an urgent care center. If you have an Emergency Condition, seek immediate care at the nearest Hospital emergency room department or call 911.

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

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

8. **Qualified Clinical Trial Expenses.** The Benefit Plan will provide coverage for all health care items and services for a Member for the treatment of cancer or any other Life-Threatening Condition that is consistent with the standard of care for an individual with the Member's diagnosis; provided, such health care items and services would have been covered under the Benefit Plan if the Member did not participate in the Qualified Clinical Trial. To be eligible for coverage, the Member must meet the requirements of a qualifying individual, as defined below.

For purposes of this section a "qualifying individual" means a Member who is eligible to participate in a Qualified Clinical Trial according to the trial protocol with respect to the treatment of cancer or other Life-Threatening Condition; and either: (A) the referring health care professional has concluded that the Member's participation in such trial would be appropriate based upon his or her diagnosis; or (B) the Member provides scientific information establishing that the Member's participation in such trial would be appropriate based upon his or her diagnosis.

Notwithstanding the above, Qualified Clinical Trial expenses do not include the following:

A. the experimental or investigational item, device or service, itself;

B. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

C. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The benefits of this paragraph are subject to any applicable Deductible, Copayment or Coinsurance provisions for similar services.

9. **Individual Case Management.**

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

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

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

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

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

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

Corporate Managed Care
165 Court Street
Rochester, NY 14647

Or, you may contact the Claims Administrator's Member Services Department at the phone number located on your identification card.

10. **Biofeedback.** The Benefit Plan will provide coverage for biofeedback when Medically Necessary.

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

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

11. **PUVA Therapy.** The Benefit Plan will provide coverage for PUVA (Psoralens and Ultraviolet A) photochemotherapy when Medically Necessary.

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

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

12. **In-Vitro Diagnostic Tests for the Detection of SARS-Co-V-2 or the Diagnosis of the virus that causes COVID-19**. Effective as of March 13, 2020 through and including May 11, 2023, the Benefit Plan will provide coverage for an in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such a test for members suspected of a COVID-19 infection, or suspected of having recovered from COVID-19 infection, that—

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

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

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

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

and which have been determined to be medically appropriate for you by your attending provider. The Benefit Plan will also provide coverage for COVID-19 at home over-the-counter (OTC) tests, regardless of whether or not a provider ordered, administered or

prescribed such tests. COVID-19 OTC tests are covered under the Prescription Drug Benefits section of the Benefit Plan and not this section. Please refer to the Prescription Drug Benefits section for coverage details, including any limits and/or exclusions.

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

In Vitro Diagnostic Test for the Detection of SARS-CoV-2 (Effective as of May 12, 2023). The Benefit Plan will provide coverage for an in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such a test for members suspected of a COVID-19 infection, or suspected of having recovered from COVID-19 infection, that—

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

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

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

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

and which have been determined to be medically appropriate for you by your attending provider.

In addition to the above, the Benefit Plan will provide coverage for any items and services provided during an office visit (including telehealth), urgent care center visit, or emergency room visit that relates to the furnishing or administration of the test or to the evaluation of the individual for purposes of determining the need for the test; and results in an order for or administration of such test. Such coverage will be provided when

rendered by an In-Network Provider or Out-of-Network Provider. Such coverage will be subject to the same Cost-Sharing (i.e. Coinsurance, Copayments or Deductibles) that is applicable to any other lab or diagnostic test covered under the Benefit Plan. Telehealth and any emergency room, urgent care center or office visits that are associated with such diagnostic testing will be subject to the same Cost-Sharing that applies to all other telehealth, emergency room, urgent care center or office visits under the Plan. Preauthorization requirements or any other medical management requirements may apply.

SECTION THIRTEEN - EMERGENCY CARE

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

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

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

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

   Facility Charges:

   In-Network. In-Network Benefits are subject to a $100 Copayment.

   Out-of-Network. Out-of-Network Benefits are subject to a $100 Copayment.

   Professional Provider Charges:

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

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

SECTION FOURTEEN - TRANSPLANTS

Transplants. The Benefit Plan covers only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, pancreas and lung transplants; and bone marrow transplants.

All transplants must be prescribed by your Specialist(s). Additionally, all transplants must be performed at Hospitals that are specifically approved and designated to perform these procedures.

The Benefit Plan covers the Hospital and medical expenses of the Member-recipient, including any Hospital and medical expenses required by you when you serve as an organ donor if the recipient is a Member. This includes organ procurement, pre-transplant and post-transplant services.

The Benefit Plan also covers pre-transplant and post-transplant services required by a non-Member acting as a donor for you, only when such non-Member does not have other coverage. Post-transplant services are limited to 90 days after the surgical procedure for the donor.

The Benefit Plan does not cover: travel expenses, lodging, meals, or other accommodations for you, a donor or guest; donor search, screening or fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

SECTION FIFTEEN – PRESCRIPTION DRUG BENEFITS

1. **Definitions.** For the purposes of this section, the following definitions shall apply:

   A. **Brand Name Drug.** A Prescription Drug that is manufactured; approved and marketed under a New Drug Application (NDA).

   B. **Designated Pharmacy.** A pharmacy that has entered into an agreement with the Prescription Drug Benefit Manager or with an organization contracting on behalf of the Prescription Drug Benefit Manager, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is an In-Network Pharmacy does not mean that it is a Designated Pharmacy.

   C. **Formulary.** The list that identifies those Prescription Drugs for which coverage may be available under this Benefit Plan. This list is subject to periodic review and modification (generally quarterly, but no more than six (6) times per Calendar Year). You may determine to which tier a particular Prescription Drug has been assigned by visiting www.excellusbcbs.com or by calling the number on your ID card.

   D. **Generic Drug.** A Prescription Drug that 1) is chemically equivalent to a Brand-Name Drug; or 2) that is identified by the Prescription Drug Benefit Manager as a Generic Prescription Drug based on available data resources. Some Prescription Drugs identified as "generic" by the manufacturer, pharmacy, or your physician may not be classified as a Generic Drug by the Benefit Plan.

   E. **In-Network Pharmacy.** A pharmacy that has:

      (1) Entered into an agreement with the Prescription Drug Benefit Manager or its designee to provide covered Prescription Drugs to Members;
      (2) Agreed to accept specified reimbursement rates for dispensing covered Prescription Drugs; and
      (3) Been designated by the Prescription Drug Benefit Manager or its designee as an In-Network Pharmacy.

      An In-Network Pharmacy can be either a retail or mail-order pharmacy.

   F. **Out-of-Network Pharmacy.** A pharmacy that has not entered into an agreement with the Prescription Drug Benefit Manager to provide Prescription Drugs to Members. The Benefit Plan will not make any payment for prescriptions or Refills filled at an Out-of-Network Pharmacy.

   G. **Prescription Drugs.** A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on the formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

H. **Prescription Drug Benefit Manager.** Express Scripts, Inc., P.O. Box 66567, St. Louis, MO 63166-6567.

I. **Prescription Drug Cost.** The amount, including a dispensing fee and any sales tax, for a covered Prescription Drug dispensed at an In-Network Pharmacy.

J. **Prescription Order or Refill.** The directive to dispense a covered Prescription Drug issued by a duly licensed Professional Provider who is acting within the scope of his or her practice.

K. **Specialty Medications.** Prescription Drugs covered under this section 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 the Claim Administrator's website at www.excellusbcbs.com or that will be mailed to you upon request. You may request the Formulary by writing or calling the Claim Administrator. Most Specialty Medications are injectables. However, the Specialty Medications on the Formulary also include select oral medications, compound medications and other types of covered Prescription Drugs.

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 the Claim Administrator's Pharmacy and Therapeutics Committee. If the Claim Administrator's records show that you are taking a Prescription Drug that will be identified on the Formulary as a Specialty Medication, the Claim Administrator will notify you in writing at least 30 days in advance of the addition of the drug to the Specialty Medication category.

L. **Specialty Pharmacy Network.** Retail and specialty pharmacies that have agreements with the Claim Administrator to dispense Specialty Medications to Members. The Group has a list of the pharmacies that participate in the Specialty Pharmacy Network. You will receive a copy of the list with this booklet and may request a copy in writing or by telephone.

M. **Tier Three Drug.** A Prescription Drug that is not a Generic Drug or a Brand Name Drug.

N. **Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by Section 6826-a of the New York Education Law.

2. **Pharmacy Benefits Provided.**

A. **Drugs from a Retail or Specialty In-Network Pharmacy.** Prescription Drugs

are available from a retail In-Network Pharmacy as follows:

(1) If you have a prescription filled with a Generic Drug, you must pay the pharmacy a $10 Copayment for up to a 30-day supply. The Copayment is waived for Members under the age of 19. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or Refill.

(2) If you have a prescription filled with a Brand Name Drug, you must pay the pharmacy a $30 Copayment for up to a 30-day supply. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or Refill.

(3) If you have a prescription filled with a Tier Three Drug, you must pay the pharmacy a $50 Copayment for up to a 30-day supply. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or Refill.

B. **Drugs from a Mail Order In-Network Pharmacy.** Prescription Drugs are available from a mail order In-Network Pharmacy as follows:

(1) If you have a prescription filled with a Generic Drug, you must pay the pharmacy a $20 Copayment for up to a 90-day supply. The Copayment is waived for Members under the age of 19. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or Refill.

(2) If you have a prescription filled with a Brand Name Drug, you must pay the pharmacy a $60 Copayment for up to a 90-day supply. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or Refill.

(3) If you have a prescription filled with a Tier Three Drug, you must pay the pharmacy a $100 Copayment for up to a 90-day supply. Benefits will be paid directly to the pharmacy for the remainder of the cost of the prescription or Refill.

C. **Drugs from an Out-of-Network Pharmacy. No benefits will be provided for Prescription Drugs that you purchase at an Out-of-Network Pharmacy.**

D. **Specialty Medications. You Must Obtain Specialty Medications through the Specialty Pharmacy Network.** In order to receive coverage for a Specialty Medication under this section, 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.

(1) **SaveonSP Program.** For certain specialty drugs, the applicable Cost-Sharing (specified in 2(A) or (B) above) is waived if you confirm your

enrollment in the SaveonSP program ("Saveon") by calling 1-800-683-1074. Specialty drugs available through Saveon are considered non-Essential Health Benefits. Specialty drugs available through Saveon are subject to the Cost-Sharing that is set by Saveon and can be found by visiting the following website: www.saveonsp.com/excellus3-tierformulary . A paper copy can be requested, free of charge, by calling the telephone number on your ID card. If you fail to confirm your enrollment in Saveon, you will be responsible for the Cost-Sharing that applies to retail and/or mail order Prescription Drugs listed in 2(A) or (B) above and not the Cost-Sharing set by Saveon and such Cost-Sharing will not count toward satisfaction of your Deductible or your Out-of-Pocket Limit. If you are not eligible for Saveon, you will be responsible for the Cost-Sharing that applies to retail and/or mail order Prescription Drugs listed in 2(A) or (B) above and not the Cost-Sharing set by Saveon and such Cost-Sharing will count toward your Out-of-Pocket Limit.

(2) **Days' Supply.** The Benefit Plan will provide benefits for Specialty Medications in a quantity of up to a 30-day supply.

3. **Covered Prescription Drugs.**

The Benefit Plan provides coverage for Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a provider authorized to prescribe and within the provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On the Formulary; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a physician or other licensed provider has issued a written order. The written order must state that

the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include, but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple sever food allergies include but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

- Modified solid food products that are low in protein , contain modified protein, or are amino acid based for the treatment of certain inherited diseases of amino acid or organic acid metabolism, as well as severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with treatment or services covered under the infertility treatment benefit in the Outpatient Care and Professional Services section of this Benefit Plan.
- Off-label cancer drugs, so long as, the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a provider.
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.
- **COVID-19 at Home Over-the-Counter (OTC) Tests.** Effective as of May 12, 2023, COVID-19 OTC tests are no longer covered under the Benefit Plan.
- **COVID-19 at Home Over-the-Counter (OTC) Tests.** Effective for tests obtained on or after January 15, 2022 through and including May 11, 2023, the Benefit Plan will provide coverage, without Cost-Sharing, Preauthorization or any other medical management requirements, for COVID-19 OTC tests administered and read at home that are authorized, approved or cleared by the Federal Drug Administration regardless of

whether or not a provider administered, ordered or prescribed such test.

COVID-19 OTC tests are limited to eight (8) tests per Member, per 30-day period. COVID-19 OTC tests obtained from participating and non-participating pharmacies, retail stores or online retailers are combined for purposes of the limitation described above. If there are multiple COVID-19 OTC tests in one package, each test in the package will count towards the limit. This limit does not apply to COVID-19 OTC tests that are ordered or prescribed by a provider. COVID-19 OTC tests that are ordered or prescribed by a provider are covered under the Medical Benefits section of this Plan and not this Prescription Drug Benefits section.

There are three (3) ways in which you may obtain COVID-19 OTC tests:

(a) **Pay out-of-pocket and submit to the Benefit Plan for reimbursement.** If you purchased and paid out-of-pocket for COVID-19 OTC tests from a Participating Pharmacy or Non-Participating Pharmacy, retail store or online retailer, you will need to submit to the Benefit Plan for reimbursement, on a form prescribed by the Claims Administrator. For a copy of a paper claim form and instructions on how to submit your claim, you may visit COVID-19 Health & Testing | Excellus BlueCross BlueShield (chooseexcellus.com) or call the customer service number on your ID card. Please refer to the **Claim and Appeal Procedures** section of your Plan Document and Summary Plan Description for the applicable claim and appeal filing timelines. You will be reimbursed for the cost of each eligible test up to a maximum reimbursement of $12 per test. If you purchased the COVID-19 OTC test on or after January 15, 2022, but prior to January 28, 2022, this $12 per test maximum reimbursement limit does not apply.

(b) **Visit an In-Network Pharmacy.** On or after January 28, 2022, the Benefit Plan has a direct payment provider network available. If you visit an In-Network Pharmacy and show your ID card, you will receive COVID-19 OTC tests without any additional out-of-pocket costs to you. You may log into your Member account online or call the customer service number on your ID card to find an In-Network Pharmacy near you. For additional information, you may also visit COVID-19 Resources and Vaccine Coverage | Express Scripts (express-scripts.com).

(c) **Order Online at Express-Scripts.com.** On or after January 28, 2022, the Benefit Plan has a direct-to-consumer shipping program available. You may go to the Express-Scripts.com website and log in. If you do not have an account, you may register for one. Once you have signed in, click “ORDER AT HOME COVID-19 TESTS”, fill out the

information and hit "submit. You may also call the customer service number on your ID card or, for additional information, visit COVID-19 Resources and Vaccine Coverage | Express Scripts (express-scripts.com).

You may request a copy of the Formulary. The Formulary is also available at www.excellusbcbs.com. You may inquire if a specific drug is covered under this Benefit Plan by contacting the Prescription Drug Benefit Manager at the number on your ID card.

4. **Refills.** The Benefit Plan covers Refills of Prescription Drugs only when dispensed at a retail, mail order or Designated Pharmacy as ordered by an authorized provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one (1) year from the original prescription date.

5. **Benefit and Payment Information.**

A. You have a three (3) tier plan design, which means that your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier one (1) and highest for Prescription Drugs on tier three (3). Your out-of-pocket expense for Prescription Drugs on tier two (2) will generally be more than for tier one (1) but less than tier three (3).

You are responsible for paying the full cost (the amount the pharmacy charges you) for any non-covered Prescription Drug and any contracted rates (the Prescription Drug Cost) will not be available to you.

B. **In-Network Pharmacies.** For Prescription Drugs purchased at a retail, mail order or designated In-Network Pharmacy, you are responsible for paying the lower of:

- The applicable cost-sharing; or
- The Prescription Drug Cost for that Prescription Drug.

C. **Out-of-Network Pharmacies.** The Benefit Plan will not pay for any Prescription Drugs that you purchase at an Out-of-Network Pharmacy (retail or mail order).

D. **Designated Pharmacies.** If you require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, the Benefit Plan may direct you to a Designated Pharmacy with whom the Prescription Drug Benefit Manager has an arrangement to provide those Prescription Drugs.

Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug from a Designated Pharmacy, you will not have coverage for

that Prescription Drug.

Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:

- Acromegaly;
- Age related macular degeneration;
- AIDS wasting syndrome;
- Allergic Rhinitis;
- Anemia, neutropenia, thrombocytopenia;
- Ankylosing Spondylitis;
- Cancer;
- Chorea associated with Huntington Disease;
- Chronic Granulomatous Disease;
- Crohn's disease;
- Cystic fibrosis;
- Enzyme deficiencies;
- Growth hormone related disorders;
- Hepatitis B;
- Hepatitis C;
- Hereditary Angioedema;
- Heterozygous Familial Hypercholesterolemia;
- Homozygous familial hypercholesterolemia;
- Hormonal disorders such as endometriosis, precocious puberty, Cushing's Syndrome;
- Hyperkalemia;
- Hyperlipidemia;
- Idiopathic Pulmonary Fibrosis;
- Immune deficiency disorders;
- Infantile Hemangioma;
- Infertility;
- Inherited disorders of metabolism;
- Iron overload;
- Juvenile idiopathic arthritis;
- Lipodystrophy;
- Migraine
- Multiple sclerosis;
- Non 24-Hour Sleep Wake Disorder;
- Osteoporosis;
- Parkinson's;
- Parkinson's Induced Psychosis;
- Peripheral stem cell collection;
- Primary Biliary Cholangitis;
- Psoriasis;

- Psoriatic arthritis;
- Pulmonary hypertension;
- Rheumatoid arthritis;
- Seizure disorders such as infantile spasm and refractory complex partial seizures;
- Short bowel syndrome;
- Toxoplasmosis;
- Ulcerative colitis;
- Vasoactive intestinal peptide tumors.

E. **Mail Order.** Certain Prescription Drugs may be ordered through a mail order In-Network Pharmacy. You are responsible for paying the lower of:

- The applicable cost-sharing; or
- The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug obtained through a mail order In-Network Pharmacy.)

To maximize your benefit, ask your provider to write your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three Refills). You will be charged the mail order cost-sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days supply written on the Prescription Order or Refill.

Prescription Drugs purchased through mail order will be delivered directly to your home or office.

The Benefit Plan will provide benefits that apply to drugs dispensed by a mail order In-Network Pharmacy to drugs that are purchased from a retail In-Network Pharmacy when that retail pharmacy has a participation agreement with the Prescription Drug Benefit Manager in which it agrees to be bound by the same terms and conditions as a mail order In-Network Pharmacy.

You or your provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting www.excellusbcbs.com or by calling the number on your ID card.

F. **Tier Status.** The tier status of a Prescription Drug may change periodically. Changes will generally be made quarterly, but no more than six (6) times per Calendar Year, based on the Prescription Drug Benefit Manager periodic tiering decisions. These changes may occur without prior notice to you. However, if you have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug as described below) you will be notified. When such changes occur, your out-of-pocket expense may change. You may access the most up to date tier status at www.excellusbcbs.com

or by calling the number on your ID card.

G. **When a Brand-Name Drug Becomes Available as a Generic Drug.** When a Brand- Name Drug becomes available as a Generic Drug, the tier placement of the Brand- Name Prescription Drug may change. If this happens, you will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned.

H. **Supply Limits.** The Benefit Plan will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one (1) cost-sharing amount for up to a 30-day supply.

Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) cost-sharing amount for a 30-day supply up to a maximum of two (2) cost-sharing amounts for a 90-day supply.

Some Prescription Drugs may be subject to quantity limits based on criteria that has been developed by the Prescription Drug Benefit Manager, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing www.excellusbcbs.com or by calling the number on your ID card. If the Benefit Plan denies a request to cover an amount that exceeds the quantity level, you are entitled to an appeal pursuant to claim and appeals procedure contained in the General Provisions section of this Benefit Plan.

I. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your cost-sharing for orally-administered anti-cancer drugs is at least as favorable to you as the cost-sharing amount, if any, that applies to intravenous or injected anticancer medications covered under the Outpatient Care and Professional Services section of this Benefit Plan.

J. **Split Fill Dispensing Program.** The split fill dispensing program is designed to prevent wasted Prescription Drugs if your Prescription Drug or dose changes. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get a 15-day supply of your Prescription Order for certain drugs filled at a Designated Pharmacy instead of the full Prescription Order. You initially pay a lesser cost-sharing based on what is dispensed. The therapeutic classes of Prescription Drugs that are included in this program are: Antivirals/Anti-infectives, Infertility, Iron Toxicity, Mental/Neurologic Disorders, Oncology, Orphan Drugs, Inflammatory agents, and Multiple Sclerosis. With the exception of infertility drugs, this program applies for the first 60 days when you start a new Prescription Drug. This program will not apply upon you or your provider's request. You or your provider can opt out by visiting

www.excellusbcbs.com or by calling the number on your ID card.

6. **Medical Management.** This Benefit Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing provider may be asked to give more details before it can be determined if the Prescription Drug is Medically Necessary.

   A. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, ask your provider to complete a preauthorization form. Should you choose to purchase the Prescription Drug without obtaining preauthorization, you must pay for the cost of the entire Prescription Drug and submit a claim to the Prescription Drug Benefit Manager for reimbursement.

   For a list of Prescription Drugs that need preauthorization, please visit www.excellusbcbs.com or call the number on your ID card. The list will be reviewed and updated from time to time. The Benefit Plan also reserves the right to require preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not covered under the Benefit Plan. Your provider may check with the Prescription Drug Benefit Manager to find out which Prescription Drugs are covered.

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

   C. **Mandatory Generic.** The Benefit Plan requires pharmacies to dispense Generic Drugs, when available. If you or your provider chooses a higher cost drug instead of the generic equivalent, you will be required to pay the applicable cost-sharing for the higher cost drug, plus the cost-difference between the Generic Drug and the higher cost drug. This cost difference will not apply to your Out-of-Pocket Limit.

7. **Limitations/Terms of Coverage.** In addition to the Exclusions section of this Benefit Plan, the following limitations/terms of coverage apply:

A. The Benefit Plan reserves the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

B. If it is determined that you may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Pharmacies may be limited. If this happens, you may be required to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the selected single In-Network Pharmacy. If you do not make a selection within 31 days of the date you are notified, a single In-Network Pharmacy will be selected for you.

C. Compounded Prescription Drugs will be covered only when the primary ingredient is a covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs over $125 require your provider to obtain preauthorization.

D. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and you are taking the drug(s) affected by the protocol, you will be notified in advance.

E. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not covered under this section but are covered under other sections of this Benefit Plan.

F. The Benefit Plan does not cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a physician's office are covered under the Outpatient Care and Professional Services section of this Benefit Plan.

G. The Benefit Plan does not cover drugs that do not by law require a prescription, except for smoking cessation drugs , over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF or as otherwise provided in this Benefit Plan. The Benefit Plan does not cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

H. The Benefit Plan does not cover Prescription Drugs to replace those that may have been lostor stolen.

I. The Benefit Plan does not cover Prescription Drugs dispensed to you while in a Hospital, nursing home, other institution, Facility, or if you are a home care patient, except in those cases where the basis of payment by or on behalf of you to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

J. The Benefit Plan reserves the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, you are entitled to an appeal as described in the claim and appeal procedure provisions of the General Provisions section of this Benefit Plan.

K. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

8. **General Conditions.**

A. You must show your ID card to a retail pharmacy at the time you obtain your Prescription Drug or you must provide the pharmacy with identifying information that can be verified by the Prescription Drug Benefit Manager during regular business hours. You must include your identification number on the forms provided by the mail order pharmacy from which you make a purchase.

B. **Drug Utilization, Cost Management.** The Benefit Plan conducts various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, you benefit by obtaining appropriate Prescription Drugs in a cost- effective manner.

SECTION SIXTEEN – EXCLUSIONS

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

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

2. **Certification Examinations.** The Benefit Plan will not provide coverage for any service or care related to a routine physical examination and/or testing to certify health status, including, but not limited to, an examination required for school, employment, insurance, marriage, licensing, travel, camp, sport or adoption.

3. **Cosmetic Services.** The Benefit Plan will not provide coverage for any services in connection with elective cosmetic surgery that is primarily intended to improve your appearance and is not Medically Necessary. Examples of the kinds of services that are often determined to be not Medically Necessary include the following: breast enlargement, rhinoplasty, and hair transplants. The Benefit Plan will, however, provide coverage for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other disease of the part of the body involved. The Benefit Plan will also provide coverage for reconstructive surgery because of congenital disease or anomaly of a child covered under this Benefit Plan that has resulted in a functional defect. The Benefit Plan will also provide coverage for services in connection with reconstructive surgery following a mastectomy, as provided in Section Nine.

4. **Court-Ordered Services.** The Benefit Plan will not provide coverage for any service or care (including evaluation, testing and/or treatment) that is ordered by a court, or that is required by a court as a condition of parole or probation, unless:

   A. The service or care would be covered under the Benefit Plan in the absence of a court order;

   B. The service or care has been pre-authorized by the Benefit Plan, if required; and

   C. It is determined, in advance, that the service or care is Medically Necessary and covered under the terms of the Benefit Plan.

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

5. **Covid-19 Testing.** Notwithstanding any provision of the Benefit Plan to the contrary, the Benefit Plan does not include coverage for COVID-19 testing in any circumstance where (1) the Benefit Plan is not required by law to cover any portion of the cost of the

test and (2) the test for COVID-19 testing is not Medically Necessary, including in cases where the test is administered primarily for purposes of determining if a person is eligible to enter a workplace or an educational facility.

COVID-19 Testing (Effective as of May 12, 2023). Notwithstanding any provision of the Plan to the contrary, the Plan does not include coverage for (1) COVID-19 OTC testing; or (2) COVID-19 diagnostic testing in any circumstance where the test is not appropriate or Medically Necessary, including in cases where the test is administered primarily for purposes of determining if a person is eligible to enter a workplace or an educational facility.

6. **Criminal Behavior.** The Benefit Plan will not provide coverage for any service or care related to the treatment of an illness, accident or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred. This exclusion will not apply to an injury or illness sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

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

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

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

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

B. Wigs, hair prosthetics, or hair implants;

C. The purchase or rental of household fixtures, including, but not limited to, elevators, escalators, ramps, seat lift chairs, stair glides, saunas, whirlpool baths, swimming pools, home tracking systems, exercise cycles, air or water purifiers, hypo-allergenic pillows, mattresses or waterbeds, massage equipment, central or unit air conditioners, humidifiers, dehumidifiers, emergency alert equipment, handrails, heat appliances, improvements made to a house or place of business, and adjustments made to vehicles.

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

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

"Experimental or investigational" means that the Claims Administrator determines the Service is:

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

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

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

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

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

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

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

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

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

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

This exclusion will not apply to Qualified Clinical Trial expenses and shall not limit in any way benefits available for prescription drugs otherwise covered under the Benefit Plan which have been approved by the FDA for the treatment of certain types of cancer, when those drugs are prescribed for the treatment of a type of cancer for which they have not been approved by the FDA, so long as the drugs so prescribed meet the requirements of the Claims Administrator's guidelines.

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

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

13. **Government Programs.** The Benefit Plan will not provide coverage for any service or care for which benefits are payable under Medicare or any other federal, state, or local government program, except when required by state or federal law. When you are eligible for Medicare, the Benefit Plan will reduce its benefits by the amount Medicare would have paid for the services. However, this exclusion will not apply to you if one of the following applies:

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

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

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

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

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

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

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

14. **Hypnosis.** The Benefit Plan will not provide coverage for hypnosis.

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

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

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

18. **Nutritional Therapy.** The Benefit Plan will not provide coverage for any service or care related to nutritional therapy, unless the Claims Administrator determines that it is Medically Necessary or that it qualifies as diabetes self-management education. The Benefit Plan will not provide coverage for commercial weight loss programs or other programs with dietary supplements.

19. **Personal Comfort Services.** The Benefit Plan will not provide coverage for any service or care that is for personal comfort or for uses not primarily medical in nature, including, but not limited to: radio, telephone, television, air conditioner, humidifier, dehumidifier, air purifiers, beauty and barber services, commodes, exercise equipment, arch supports, or orthotics used solely for sports.

20. **Private Duty Nursing Service.** The Benefit Plan will not provide coverage for private duty nursing services, except if the attending physician certifies in writing that a certified registered nurse was not available, provided in any case that such nurse is one who does not ordinarily reside in the home of the Member and is not a member of the Member's family.

21. **Prohibited Referral.** The Benefit Plan will not provide coverage for any pharmacy, clinical laboratory, radiation therapy, physical therapy, x-ray, or imaging services that were provided pursuant to a referral prohibited by the New York Public Health Law.

22. **Reproductive Procedures.** The Benefit Plan will not provide coverage for the following

reproductive procedures or services: gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), costs associated with an ovum or sperm donor (including the donor's medical expenses), cryopreservation and storage of embryos (except in connection with in-vitro fertilization), ovulation predictor kits, reversal of tubal ligations, reversal of vasectomies, costs for services related to surrogate motherhood (not otherwise covered under the Benefit Plan), or cloning and related costs.

23. **Routine Care of the Feet.** The Benefit Plan will not provide coverage for services related to routine care of the feet, including but not limited to, corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, toenails, or symptomatic complaints of the feet. The Benefit Plan will, however, provide coverage for foot orthotics under your benefits for orthotics.

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

25. **Self-Help Diagnosis, Training, and Treatment.** The Benefit Plan will not provide coverage for any service or care related to self-help or self-care diagnosis, training and treatment for recreational, educational, vocational, or employment purposes.

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

27. **Special Charges.** The Benefit Plan will not provide coverage for charges billed to you for telephone consultations (except telemedicine and telehealth services covered in accordance with the Excellus BlueCross BlueShield telemedicine and telehealth medical policy or the Telehealth/Telemedicine provision described in the Professional Services section of this Benefit Plan), 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.

28. **Unlicensed Provider.** The Benefit Plan will not provide coverage for any service or care that is provided or prescribed by an unlicensed provider; or that is outside the scope of licensure of the duly licensed provider rendering the service or care.

29. **Vision and Hearing Exams, Therapies and Supplies.** The Benefit Plan will not provide coverage for any service or care related to routine vision exams, vision or hearing therapy, eyewear, vision training, or orthoptics.

30. **Weight Loss Services.** The Benefit Plan will not provide coverage for any service or care in connection with weight loss programs. The Benefit Plan will also not provide benefits for any covered service or care set forth in this booklet when rendered in connection with weight reduction or dietary control, including, but not limited to, laboratory services, and gastric stapling, gastric by-pass, gastric bubble or other surgery for treatment of obesity, unless Medically Necessary.

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

SECTION SEVENTEEN - WAITING PERIODS

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

SECTION EIGHTEEN - COORDINATION OF BENEFITS

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

1. **When You Have Other Health Benefits.** It is not unusual to find yourself covered by two health insurance contracts, plans, programs, or policies ("plans") providing similar benefits both issued through or to groups. When that is the case and you receive an item of service that would be covered by both plans, the Benefit Plan will coordinate benefit payments with any payment made under the other plan. One plan will pay its full benefit as the primary plan. The other plan will pay secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance plan:

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

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

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

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

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

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

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

   B. If you are covered under one plan as an employee, subscriber, or primary member and you are only covered as a family member under the other plan, the plan

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

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

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

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

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

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with custody of the child;

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

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

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

3. **Payment of the Benefit When This Benefit Plan Is Secondary.** When this Benefit Plan is secondary, the benefits of this Benefit Plan will be reduced so that the total benefits payable under the other plan and this Benefit Plan do not exceed your expenses

for an item of service. However, the Benefit Plan will not pay more than it would have paid if it were primary.

The Benefit Plan counts as actually paid by the primary plan any items of expense that would have been paid if you had made the proper and timely claim. The Group and/or the Claims Administrator will request information from that plan so the Claims Administrator can process your claims. If the primary plan does not respond within 30 days, the Claims Administrator may assume that the primary plan's benefits are the same as the Benefit Plan's. If the primary plan sends the information after 30 days, the Benefit Plan will adjust its payment, if necessary.

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

4. **Right to Receive and Release Necessary Information.** The Benefit Plan, the Group and the Claims Administrator have the right to release or obtain information that they believe necessary to carry out the purpose of this section. The Benefit Plan, the Group and the Claims Administrator need not tell you or obtain anyone's consent to do this except as required by Article 25 of the New York General Business Law. The Benefit Plan, the Group and the Claims Administrator will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish any information that the Benefit Plan, the Group and the Claims Administrator request. If you do not furnish the information, the Benefit Plan has the right to deny payments.

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

6. **The Benefit Plan's Right to Recover Overpayment.** In some cases the Benefit Plan may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund to the Benefit Plan the amount by which it should have reduced the payment it made. The Benefit Plan also has the right to recover the overpayment from the other health benefits plan if the Benefit Plan has not already received payment from that other plan. You must sign any document that the Group and/or the Claims Administrator deems necessary to help the Benefit Plan recover any overpayment.

SECTION NINETEEN - TERMINATION OF YOUR COVERAGE

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

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

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

   Employee Coverage Ends. Your coverage under the Benefit Plan will terminate on the earliest of the following dates:

   A. The date the Benefit Plan terminates, in whole or in part;

   B. The last day of the period for which the required contribution has been paid;

   C. The end of the month in which your employment ends for any reason, including termination and voluntary resignation;

   D. The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA);

   E. The end of the month in which you change to an employee classification that is not benefits-eligible;

   F. The date of your death.

   G. The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; or

   H. The date you (or any person seeking coverage on your behalf) makes an intentional representation of material fact.

   Dependent Coverage Ends: Coverage for your dependent spouse, domestic partner or child will end on the earliest of the following dates:

   A. The date the Benefit Plan terminates, in whole or in part;

   B. The date the employee's eligibility or coverage under the Benefit Plan terminates;

   C. The end of the month the dependent child, or for the dependent spouse or domestic partner the date the spouse or domestic partner, no longer qualifies as a dependent

under the Benefit Plan;

D. The last day of the period for which the required contribution has been paid;

E. The date dependent coverage under the Benefit Plan is terminated;

F. The date of the dependent's death or the employee's death.

G. The date the dependent child, spouse or domestic partner (or any person seeking coverage on behalf of the dependent child, spouse or domestic partner) performs an act, practice or omission that constitutes fraud; or

H. The date the dependent child, spouse or domestic partner (or any person seeking coverage on behalf of the dependent child, spouse or domestic partner) makes an intentional representation of material fact.

3. **Temporary Continuation of Coverage.** Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write your Group to find out if you are entitled to temporary continuation of coverage under COBRA.

SECTION TWENTY - GENERAL PROVISIONS

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

2. **Notice.** Any notice that the Group or the Claims Administrator give to you under this Benefit Plan will be mailed to your address as it appears in the records of the Claims Administrator or in the records of the Group.

3. **Your Medical Records.** In order to provide your coverage under this Benefit Plan, it may be necessary for the Group and/or the Claims Administrator to obtain your medical records and information from Facilities, Professional Providers, Providers of Additional Health Services, and pharmacy who provided services to you. Actions to provide that coverage include processing your claims, reviewing grievances or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you become covered under this Benefit Plan, you automatically give the Group and/or the Claims Administrator permission to obtain and use those records for those purposes.

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

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

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

6. **Choice of Law.** All disputes relating to this Benefit Plan shall be governed by Federal law and, as applicable, the laws of the State of New York, to the extent not pre-empted by ERISA.

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

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

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

10. **Subrogation.** The purpose of this Benefit Plan is to provide benefits for expenses that are not covered by another party. All payments made under this Benefit Plan are conditioned on the understanding that the Benefit Plan will be repaid (either through reimbursement or subrogation) for benefits that related to an illness, injury or health condition for which you (or your estate, legal guardian or legal representative), may have or assert for a tort or contractual recovery. Recovery rights apply to any sums you receive by settlement, verdict, or otherwise for the illness, injury or health condition. This Benefit Plan is always secondary to any recovery you make from Worker's Compensation (no matter how the settlement or award is characterized for damages) and is always secondary to any automobile coverage for first party benefits.

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

    The Benefit Plan will be subrogated to all claims, demands, actions and rights of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including your own). The amount of such subrogation will

equal the total amount paid under the Benefit Plan arising out of the illness, injury or health condition that is the basis for any claim you (or your estate, legal guardian or legal representative) may have or assert. The Benefit Plan may assert its subrogation rights independently of you or it may choose to assert its reimbursement rights against your recovery.

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

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

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

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

11. **Who May Change This Benefit Plan.** The Benefit Plan may not be modified; amended; or changed, except in writing, and signed by the Associate Vice President of Human Resources and/or Director of Benefits of the Group or a person duly authorized in writing by the Associate Vice President of Human Resources and/or Director of Benefits of the Group to make changes to this Benefit Plan. No employee; agent; or other person is authorized to interpret; amend; modify; or otherwise change the Benefit Plan in a manner that expands or limits the scope of coverage; or the conditions of eligibility; enrollment; or participation, unless in writing and signed by the Associate Vice President of Human Resources and/or Director of Benefits of the Group or by a person duly authorized in writing by the Associate Vice President of Human Resources and/or Director of Benefits of the Group.

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

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

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

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

16. **Right to Develop Guidelines and Administrative Rules.** The Group and/or the Claims Administrator may develop or adopt standards that describe in more detail when payment will or will not be made under this Benefit Plan. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether emergency care in the outpatient department of a Facility was necessary; or whether certain services are Skilled Care. Those standards will not be contrary to the descriptions in this booklet. If you have a question about the standards that apply to a particular benefit, you may contact the Claims Administrator and it will explain the standards or send you a copy of the standards. The Group and/or the Claims Administrator may also develop administrative rules pertaining to enrollment and other administrative matters. The Group and/or the Claims Administrator shall have all the powers necessary or appropriate to enable them to carry out their duties in connection with the administration of their respective duties under this Benefit Plan.

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

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

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

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

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

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

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

20. **Service Marks.** Excellus Health Plan, Inc. ("Excellus") is an independent corporation organized under the Insurance Law of New York State. Excellus also operates under licenses with the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans, which licenses Excellus to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus does not act as an

agent of the Blue Cross and Blue Shield Association. Excellus is solely responsible for its obligations created under the Administrative Services Contract between the Group and Excellus.

21. **Inter-Plan Arrangements Disclosure - Out-of-Area Services.** The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of the Claims Administrator's Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program.

Typically, when accessing care outside the Service Area, you will obtain care from health care providers that have a contractual agreement (i.e., are "In-Network Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Out-of-Network Providers. The Claims Administrator's payment practices in both instances are described below.

A. **BlueCard® Program.** Under the BlueCard® Program, when you access covered health care services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible to Group for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its In-Network Providers.

Whenever you access covered health care services outside the Claims Administrator's Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

(1) The provider's billed covered charges for your covered services; or

(2) The negotiated price that the Host Blue makes available to the Claims Administrator. This negotiated price will be one of the following:

(a) Often, a simple discount that reflects an actual price that the Host Blue pays to your provider;

(b) Sometimes, an estimated price that takes into account special arrangements with your provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges; or

(c) Occasionally, an average price based on a discount that result in expected average savings for similar types of providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Claims Administrator uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate your liability for any covered health care services according to applicable law.

B. **Calculation of Member Liability for Services of Out-of-Network Providers outside the Claims Administrator's Service Area.** The Allowable Expense definition in this booklet, as amended from time-to-time, describes how the Claims Administrator's payment (the "Allowable Expense") for covered services of Out-of-Network Providers outside its Service Area is calculated. The Allowable Expense may be based upon the amount provided to the Claims Administrator by the Host Blue or the payment it would make to Out-of-Network Providers inside its Service Area. Regardless of how the Allowable Expense is calculated, you will be liable for the amount, if any, by which the provider's actual charge exceeds the Allowable Expense, which amount is in addition to any other cost-sharing (Deductible, Copayment or Coinsurance) required by this Benefit Plan.

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

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

When submitting a claim form, include:

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

(8) The date of service.

Payments will be made directly to In-Network Providers. Payments for services rendered by an Out-of-Network Provider (other than those that are subject to the surprise bill protections) may be made payable to the Member. Payment for services rendered by an Out-of-Network Provider that are subject to the surprise billing protections as described in the **Protections from Surprise Bills** section of the Benefit Plan will be made directly to the Out-of-Network Provider. Submit claim forms to the Claims Administrator at:

For Medical Claims:

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

For Prescription Drug Claims:

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

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

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

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

Post-Service Claims
Post-service claims are those claims that are filed for payment of benefits after health care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. This 30-day period may be extended by

the Claims Administrator for up to 15 days. In addition, the Claims Administrator will notify you within the initial 30-day period if additional information is required to process the claim, and will put your claim on hold until all information is received.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appealing a Denied Claim
If you disagree with a claim determination after following the above steps, you can contact Claims Administrator in writing to formally request an appeal. In your appeal, you may submit written comments, documents, records, and other information relating to your claim for benefits. You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

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

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

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

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

(3) The provider's name,

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

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

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

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

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

medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

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

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

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

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

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

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

Appeal Process
A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Your participation in the Benefit Plan includes your consent to this referral and

the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal Determinations

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

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

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

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

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

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

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

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

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

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

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

(6) The following information:

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

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

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

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

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

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

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

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

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

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

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

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

final adverse determination.

To be eligible for external review, the final adverse determination issued through the first level of the internal appeal process must be based on a determination:

i. that the requested service does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or
ii. that the requested service is experimental or investigational,
iii. for a rescission of coverage, or
iv. involving consideration of whether the Benefit Plan is complying with the surprise billing and Cost-Sharing protections of the No Surprises Act (See the section of this document entitled **Protection from Surprise Bills**): or
v. involving whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the Benefit Plan's wellness program (if any); or
vi. involving whether the Benefit Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) and its implementing regulations.

For purposes of this section a rescission of coverage is a retroactive termination of coverage under the Benefit Plan, except in cases where you fail to pay any required contribution to the cost of coverage under the Benefit Plan. You do not have the right to an external review of any other determinations, even if those other determinations affect your coverage.

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

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

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

Effect of External Review Determination
A determination on external review is binding on the Benefit Plan and the claimant, except to the extent that other remedies are available under applicable

state or federal law. However, a decision by the external reviewer does not preclude the Benefit Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Benefit Plan to provide benefits or payment on a claim, the Benefit Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Benefit Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

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

Time to Sue

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

Appointment of Authorized Representative

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

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

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

(a) request mid-year enrollment in medical coverage due to a HIPAA special enrollment event where the special enrollment period otherwise would include any day of the Outbreak Period;
(b) elect to initially enroll in COBRA continuation coverage if the 60-day initial election period otherwise would include any day of the Outbreak Period;
(c) make an initial or any subsequent COBRA premium payment if the time period (or the grace period) for making the COBRA premium payment otherwise would include any day of the Outbreak Period;

(d) provide a required notice to the Benefit Plan of a COBRA qualifying event, if the time period for providing the notice otherwise would include any day of the Outbreak Period;
(e) file an initial claim for benefits under the Benefit Plan if the timely filing period otherwise would include any day of the Outbreak Period;
(f) file an internal or external appeal (if applicable) in response to an adverse benefit determination if the time period for filing an internal or external appeal otherwise would include any day of the Outbreak Period; or
(g) perfect a request for external review (if applicable) in response to a notice that the request is not complete if the time period for perfecting the request otherwise would include any day of the Outbreak Period.

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

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

For purposes of this section, the "Outbreak Period" is the period beginning on the later of (1) March 1, 2020 or (2) the "Applicable Event Date" (as defined below) and ending on the earlier of (A) one year from the Applicable Event Date or (B) 60 days after May 11, 2023.

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

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

(g)	Perfection of external appeal	Date of receipt of notice of need for information