These are your
HAMILTON COLLEGE PLAN BENEFITS

This booklet explains the benefits available to you under the self-funded health benefits program, maintained by Hamilton College (the "Benefit Plan"). The Benefit Plan is funded by Hamilton College (the "Group"). Excellus Health Plan, Inc. is the Claims Administrator for the Benefit Plan. Excellus Health Plan, Inc. is not acting as an insurer of your benefits. Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield ("Excellus BlueCross BlueShield"), administers claims for benefits under the Benefit Plan on behalf of the Group and does not insure your benefits. Excellus BlueCross BlueShield provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims. Excellus BlueCross BlueShield is a nonprofit independent licensee of the BlueCross BlueShield Association. You should keep this booklet with your other important papers so it is available for your future reference.

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

In-Network Benefits. In-Network Benefits are the highest level of coverage available. In-Network Benefits apply when your care is provided by In-Network Providers. Except in emergencies, you should always consider receiving health services first through In-Network Providers. You will be responsible for paying any Cost-Sharing amount that applies to covered services.

Out-of-Network Benefits. The Out-of-Network Benefits portion of this Benefit Plan covers health care services described in this booklet when you choose to receive the covered services from Out-of-Network Providers. When you receive Out-of-Network Benefits, you will incur the higher out-of-pocket expenses. You will be responsible for paying any Cost-Sharing amount that applies to covered services, as well as for paying any difference between the Allowable Expense and the provider's charge.

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

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SECTION ONE - INTRODUCTION AND DEFINITIONS

1. **Your Coverage under This Benefit Plan.** The terms of this self-funded Benefit Plan are effective as of January 1, 2019. Under the Benefit Plan, the benefits described in this booklet will be provided to employees or members of the Group and their covered family members, subject to eligibility requirements. You should keep this booklet with your other important papers so that it is available for your future reference.

2. **Definitions.**

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

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

   The Allowable Expense for In-Network Providers 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, or the In-Network Provider's charge, if less. However, when the In-Network Provider's charge is less than the amount the Benefit Plan has negotiated with the In-Network Provider, your Cost-Sharing amount will be based on the In-Network Provider's charge.

   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 an amount based on the In-Network Provider's negotiated rate, or the Facility's charge, if less.

   (2) **Facilities outside the Service Area.**
   For Facilities outside the Service Area, the Allowable Expense will be an amount based on the In-Network Provider's negotiated rate, or the Facility's charge, if less.

   (3) **For a Professional Provider or a Provider of Additional Health Services in the Service Area (other than for Ground Ambulance or Emergency Services).**
   For a Professional Provider or a Provider of Additional Health Services in the Service Area, the Allowable Expense will be an amount based on the In-Network Provider's negotiated rate, or the Professional Provider or Provider of Additional Health Services' charge, if less.

(4) **For a Professional Provider or a Provider of Additional Health Services Outside the Service Area (other than for Ground Ambulance or Emergency Services).**
For a Professional Provider or a Provider of Additional Health Services outside the Service Area, the Allowable Expense will be the 90th percentile of the Usual, Customary and Reasonable ("UCR") rate or charge, as supplied by Fair Health, or the Professional Provider or Provider of Additional Health Services' charge, if less.

(5) **Ground Ambulance or Emergency Services.** The Allowable Expense for an Out-of-Network Provider for ground ambulance or Emergency Services will be the Out-of-Network Provider's charge. You are responsible for any Cost-Sharing.

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

The Out-of-Network Provider's actual charge may exceed the Allowable Expense. You must pay the difference between the Allowable Expense and the Out-of-Network Provider's charge. Contact Excellus BlueCross BlueShield at the number on your ID card or visit www.excellusbcbs.com for information on your financial responsibility when you receive services from an Out-of-Network Provider.

The Benefit Plan reserves the right to negotiate a lower rate 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.

E. **Coinsurance.** A charge, expressed as a percentage of the Allowable Expense, that you must pay for certain services covered under this Benefit Plan. You are

responsible for the payment of any Coinsurance directly to the provider.

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

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

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

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

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

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

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

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

(4) Serious disfigurement of such person.

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

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

K. **Emergency Services.** A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the

Hospital, such further medical examination and treatment as are required "to stabilize" the patient.

L. **Facility.** A Hospital; ambulatory surgery facility; birthing center; dialysis center; rehabilitation facility; 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. **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.

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

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

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

R. **Medical Necessity.** See Section Three.

S. **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.

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

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

V. **Out-of-Network Provider.** A Facility, Professional Provider or Provider of Additional Health Services that does not have a provider agreement with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan to provide

health services to Members.

W. **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.

X. **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.

Y. **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.

Z. **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.

AA. **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.

BB. **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.

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

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

SECTION TWO - WHO IS COVERED

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

   A. Your spouse. If you are divorced or your marriage has been annulled, your former spouse is not covered. The term "spouse" means a person of the same or opposite gender that is legally married to you, the employee.

   B. Your domestic partner. Domestic partner includes an unmarried person of the same or opposite sex that is at least 18 years old and not related to you, the employee, by marriage or blood in a way that would bar marriage. You and your domestic partner must reside together in a committed relationship and have been each other's sole domestic partner for at least six months. In order to prove the existence of a domestic partnership, all of the following criteria must be met:

      (1) **Economic Interdependence.** The partners must be economically interdependent upon each other. This may be proven by:

         i. Registration as the employee's domestic partner, if living in a city or county providing for registration of domestic partners, and providing a copy of the appropriate certificate to the Benefit Plan; or

         ii. Submission to the Benefit Plan of a signed affidavit, in a form acceptable to the Group, confirming an existing and established relationship of intended future duration that involves economic interdependency.

      (2) **Proof of Cohabitation.** The partners must prove that they are cohabitating. Cohabitation may be proved by presenting documentation, such as drivers' licenses or tax returns, demonstrating that the partners are living together.

      (3) **Other Indicia.** At least two other indicia of a domestic partnership must be provided: (i) a joint bank account; (ii) a joint credit or charge card; (iii) a joint obligation on a loan; (iv) status as authorized signatory on the partner's bank account, credit card or charge card; (v) joint ownership or holding of investments; (vi) joint ownership of residence; (vii) joint ownership of real estate other than residence; (viii) listing of both partners as tenants on a lease of the shared residence; (ix) shared rental payments of a residence (need not be shared 50/50); (x) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence; (xi) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills), which need not be shared 50/50; (xii) shared household budget for purposes of receiving government benefits; (xiii) status of one as representative payee for the

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

C. Your child who is under the age of 26. Coverage lasts until the end of the month in which the child turns age 26. A spouse of a child is not covered.

D. Your unmarried child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attaining age 26 shall continue to be covered while your coverage under this Benefit Plan remains in effect and the child remains in such condition, if you submit proof of your child's incapacity within 31 days of your child attaining age 26. The Group and the Claims Administrator have the right to request proof as to whether or not your child continues to qualify under this provision.

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

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

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

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

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

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

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

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

4. **Types of Coverage Offered under the Benefit Plan.** In addition to individual coverage, the following types of coverage are offered under this Benefit Plan:

   A. Family Coverage. If family coverage applies, then you, the employee or member of the Group, and your spouse or domestic partner, and your child or children as described in subparagraph 1.C and D above are covered.

   B. Spousal Coverage. If spousal coverage applies, then only you, the employee or member of the Group, and your spouse or domestic partner as described in subparagraph 1.A and B above are covered.

   C. Child(ren) Coverage. If Child(ren) coverage applies, then only you, the employee or member of the group, and your child or children as described in subparagraph 1.C and D above are covered.

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

indicate is applicable. You may call the Group or the Claims Administrator if you have any questions about which type of coverage applies to you.

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

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

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

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

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

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

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

      (1) Termination of employment;

      (2) Termination of the other plan or contract;

(3) Death of the spouse or domestic partner;

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

(5) Reduction in the number of hours worked;

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

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

(8) Cessation of eligible child status;

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

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

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

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

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

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

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

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

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

SECTION THREE - MEDICAL NECESSITY AND PRIOR APPROVAL

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

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

   In determining if a Service is Medically Necessary, the Claims Administrator will also consider:

   A. Reports in peer reviewed medical literature;

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

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

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

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

   F. Any other relevant information brought to our attention.

   Services will be deemed Medically Necessary only if:

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

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

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

   D. They are provided in accordance with generally-accepted standards of medical practice;

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

F. They are not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease; and

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

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

3. **Services Subject To Prior Approval.** Prior approval is required before you receive certain services covered under this Benefit Plan. The services subject to prior approval are:

A. Advance imaging such as MRI, MRA, CT, nuclear medicine, nuclear cardiology, PET and other imaging procedures developed from time to time.

B. Durable medical equipment with a cost in excess of $200.

C. Home care services.

D. Infusion therapy services.

E. Inpatient admissions, other than for maternity.

F. Organ and tissue transplants (all services).

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

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

immediate admission for implantation shall be considered an Emergency Condition for purposes of this paragraph.

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

5. **Your Right to Appeal.** If you or your Professional Provider disagrees with the Claims Administrator's decision, you may appeal by following the claim and appeal procedures provisions contained in Section Seventeen.

6. **Failure to Seek Approval.** If you fail to seek prior approval for benefits subject to this section, other than with respect to any benefits received due to an Emergency Condition, the Benefit Plan will pay the lesser of (A) $500 less than what would otherwise have been paid for the care, or (B) 50% of the amount that would otherwise have been paid for the care. You must pay the remaining charges. The Benefit Plan will pay the amount specified above only if it is determined that the care was Medically Necessary. If it is determined that services were not Medically Necessary, you will be responsible for paying the entire charge for the service.

SECTION FOUR - COST-SHARING EXPENSES

1. **Deductible.** Except where stated otherwise, you must pay the first $275 of Allowable Expenses incurred for In-Network services and $1,100 of Allowable Expenses incurred for Out-of-Network services covered under the Benefit Plan during each Calendar Year. If you have other than individual coverage, the Deductible applies to each person covered under the Benefit Plan. However, after Deductible payments for any and all persons covered under the Benefit Plan total $550 (two person coverage) or $825 (family coverage) of Allowable Expenses for In-Network services and $2,200 (two person coverage) or $2,750 (family coverage) of Allowable Expenses for Out-of-Network services covered under the Benefit Plan in a Calendar Year, no further Deductible will be required for any person covered under the Benefit Plan for that Calendar Year. You must also pay a separate $50 Deductible for each person covered under the Benefit Plan for In-Network and Out-of-Network home care services covered under the Benefit Plan during each Calendar Year. The home care Deductible applies to each Member covered under the Benefit Plan and counts toward satisfaction of the $275 (In-Network)/$1,100 (Out-of-Network) individual Deductible, $550 (In-Network)/$2,200 (Out-of-Network) two person Deductible, or the overall $825 (In-Network)/$2,750 (Out-of-Network) family Deductible.

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

2. **Coinsurance.** Except where stated otherwise, after you have satisfied the annual Deductible described above, you will be responsible for a percentage of the Allowable Expense for many In-Network and Out-of-Network services under the Benefit Plan, which is your Coinsurance. Your Coinsurance for In-Network Benefits is 10% and for Out-of-Network Benefits is 30%, unless otherwise noted in the section where the service is described.

3. **Copayments.** You must pay a Copayment for many covered In-Network services at the time services are rendered. Except where stated otherwise, the In-Network Copayment under this Benefit Plan is $25 for a primary care physician and $40 for a specialist.

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

   When you receive covered services from an Out-of-Network Provider, the Claims Administrator will apply nationally recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services you received. Sometimes,

applying these rules will change the way that the Claims Administrator pays for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. As an example, your provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. The Claims Administrator will make one inclusive payment in that case, rather than a separate payment for each billed code. Another example of when the payment rules will be applied to a claim is when you have surgery that involves two surgeons acting as "co-surgeons". Under the payment rules, the claim from each provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If the Claims Administrator receives a claim that does not have the correct modifier, the Claims Administrator will change it and make the appropriate payment.

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

5. **Out-of-Pocket Limit.** When you have expended $1,750 for services received from In-Network Providers for Deductibles (including the home care Deductible), Coinsurance and Copayments or $3,500 for services received from Out-of-Network Providers for Deductibles (including the home care Deductible), Coinsurance and Copayments in a Calendar Year, the Benefit Plan will provide coverage for 100% of the Allowable Expense for covered services for the remainder of the Calendar Year. If you have other than individual coverage, the Out-of-Pocket Limit applies to each person covered under the Benefit Plan. However, when members of the same family covered under the Benefit Plan have paid an aggregate of $3,500 (two-person) or $5,250 (family) for Deductibles (including the home care Deductible), Coinsurance and Copayments for services received from In-Network Providers; or $7,000 (two-person) or $8,750 (family) for Deductibles (including the home care Deductible), Coinsurance and Copayments for services received from Out-of-Network Providers in a Calendar Year, the Benefit Plan will provide coverage for 100% of the Allowable Expense for covered services for the remainder of the Calendar Year. Any charges of an Out-of-Network Provider that are in excess of the Allowable Expense will remain your responsibility.

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

SECTION FIVE - INPATIENT CARE

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

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

   A. Additional charges for special duty nurses;

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

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

   D. Custodial care (see Section Thirteen); 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. **Mental Health Disorder Inpatient Services.** The Benefit Plan provides coverage for inpatient mental health care services relating to the diagnosis and treatment of Mental Health Disorders comparable to other similar Hospital, medical and surgical coverage provided under this Benefit Plan. Coverage for inpatient services for Mental Health Disorders 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 Excellus BlueCross BlueShield.

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

C. **Substance Use Disorder Inpatient Services.** The Benefit Plan covers inpatient substance use services relating to the diagnosis and treatment of a Substance Use Disorder. This includes coverage for detoxification and rehabilitation services for a Substance Use Disorder. 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 Substance Use Disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities that provide services defined in 14 NYCRR 819.2(a)(1), 820.3(a)(1) and (2) and Part 817; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission or a national accreditation organization recognized by Excellus BlueCross BlueShield 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 60 days in a Calendar Year.

In-Network Benefits and Out-of-Network Benefits for a Skilled Nursing Facility will both be counted toward the 60-day per year limit described above.

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

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

4. **Maternity 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, even if you do not add the newborn to your coverage or extend your coverage to include the newborn as described in Section Two of this booklet, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. The Benefit Plan will also provide coverage for any additional days of such care that the Claims Administrator determines are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum coverage period, the Benefit Plan will provide coverage of the home care visit furnished by the type of home care agency described in Section Seven of this booklet. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later.

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

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

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 In-Network Benefits for newborn nursery care) are covered at 90% of the Allowable Expense, after Deductible. In-Network Benefits for newborn nursery care are covered at 90% of the Allowable Expense.

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

SECTION SIX - OUTPATIENT CARE

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

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

   In-Network. In-Network Benefits are covered at 90% 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 90% of the Allowable Expense, after Deductible.

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

3. **Imaging.** The Benefit Plan will provide coverage for diagnostic and routine imaging procedures, including x-rays, ultrasound, computerized axial tomography ("CAT") and positron emission tomography ("PET") scans, and magnetic resonance imaging ("MRI") procedures. Prior approval is required for certain procedures as described in Section Three.

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

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

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

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

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

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

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

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

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

   In-Network. In-Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

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

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

   In-Network. In-Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

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

8. **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 90% of the Allowable Expense, after Deductible.

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

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

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

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

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

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

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

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

10. **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. At a minimum, the Benefit Plan will provide coverage for one screening each Calendar Year for women age 18 and older under this section and Section Nine. Cervical cytology screening shall mean a pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

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

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

11. **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, 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 subject to a $25 Copayment.

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

12. **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 subject to a $40 Copayment.

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

13. **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 subject to a $40 Copayment.

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; 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 Excellus BlueCross BlueShield.

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

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

15. **Substance Use Disorder 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 Substance Use Disorders, 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 Substance Use Disorders 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 a Substance Use Disorder 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 $40 Copayment.

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

16. **Infertility Treatment Services.** The Benefit Plan will provide coverage for Medically Necessary outpatient Facility care in connection with infertility treatment services provided by a Professional Provider pursuant to Section Nine. You are responsible for any applicable Cost-Sharing provisions for similar services.

17. **Diagnostic Colonoscopy.** The Benefit Plan will provide coverage for diagnostic colonoscopy screenings.

In-Network. In-Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

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

SECTION SEVEN - HOME CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. **Benefits for Home Care.**

In-Network. In-Network Benefits are covered at 90% of the Allowable Expense, after a $50 Deductible.

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

SECTION EIGHT - HOSPICE CARE

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

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

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

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

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

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

   B. Day care services provided by the hospice organization;

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

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

      (2) Physical therapy;

      (3) Speech therapy;

      (4) Occupational therapy;

      (5) Respiratory therapy;

      (6) Social services;

      (7) Nutritional services;

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

(9) Medical supplies;

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

(11) Durable medical equipment; and

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

D. Medical care provided by a physician.

4. **Number of Days.** Coverage for bereavement counseling is limited to five (5) per Calendar Year for your family, either before or after your death. In-Network Benefits and Out-of-Network Benefits will both be counted towards the five (5) 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 100% of the Allowable Expense.

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

SECTION NINE - PROFESSIONAL SERVICES

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

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

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

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

      In-Network. In-Network Benefits are covered at 90% 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 90% 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 subject to a $25 Copayment for a primary care physician and a $40 Copayment for a specialist.

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

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, 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 subject to a $25 Copayment.

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 90% 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 $40 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.

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

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

6. **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 90% 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 Medically Necessary terminations of pregnancy.

In-Network. In-Network Benefits for complications of pregnancy are covered at 90% 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 90% 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 90% 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 one (1) exam limit described above.

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

Out-of-Network. Out-of-Network Benefits are covered at 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 will provide coverage for diagnostic and routine laboratory and pathology services.

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

Out-of-Network. Out-of-Network Benefits are covered at 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 $40 Copayment.

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

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

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

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

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

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

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

D. **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 $25 Copayment for a primary care physician or $40 Copayment for a specialist.

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

E. **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 $25 Copayment for a primary care physician or $40 Copayment for a specialist.

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

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

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

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

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

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

    In-Network. In-Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

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

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

    In-Network. In-Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

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

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

In-Network. In-Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

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

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

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

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

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

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

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

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

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

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

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

15. **Screenings for Prostate Cancer.** The Benefit Plan covers an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. The Benefit Plan also covers standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate 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.

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

    In-Network. In-Network Benefits for allergy testing are subject to a $25 Copayment for a primary care physician or a $40 Copayment for a specialist. In-Network Benefits for allergy 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.

17. **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 $25 Copayment.

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

18. **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 90% of the Allowable Expense, after Deductible.

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

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

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

    B. **Coverage Provided for Individuals 21 to 44 Years of Age.** The benefits provided by this paragraph are available only to Members covered under this Benefit Plan who are between the ages of 21 and 44 as of the date the services are rendered.

    C. **Coverage Only Provided for Appropriate Candidates.** Coverage under this paragraph will only be provided to "Appropriate Candidates" within the age

group described in subparagraph B. An Appropriate Candidate is an individual determined to be an Appropriate Candidate by the treating physician, in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society of Reproductive Medicine.

D. **Covered Services.** Subject to the other provisions of this paragraph and this booklet, the Benefit Plan will provide benefits under this paragraph for:

(1) Medical and surgical procedures, such as artificial insemination, intrauterine insemination, and dilation and curettage ("D & C"), that would correct malformation, disease or dysfunction resulting in infertility; and

(2) Services in relation to diagnostic tests and procedures necessary:

(a) To determine infertility; or

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

(i) Hysterosalpingogram;

(ii) Hysteroscopy;

(iii) Endometrial biopsy;

(iv) Laparoscopy;

(v) Sono-hysterogram;

(vi) Post-coital tests;

(vii) Testis biopsy;

(viii) Semen analysis;

(ix) Blood tests;

(x) Ultrasound; and

(xi) Other Medically Necessary diagnostic tests and procedures, unless otherwise excluded in accordance with the Claims Administrator's administrative guidelines with respect to infertility.

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

F. **Services Must Be Received from Eligible Providers.** Services covered under this paragraph must be received from "Eligible Providers" as according to the Claims Administrator's administrative guidelines. In general, an Eligible Provider is defined as a health care provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine for the performance of procedures and treatments for the diagnosis and treatment of infertility.

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

(1) In-Vitro Fertilization;

(2) Gamete Intra-Fallopian Transfer (GIFT);

(3) Zygote Intra-Fallopian Transfer (ZIFT);

(4) Reversal of elective sterilizations, including vasectomies and tubal ligations;

(5) Cloning;

(6) Sperm banking and donor fees associated with artificial insemination or other procedures;

(7) Other procedures or categories of procedures excluded by the Claims Administrator in accordance with its administrative guidelines. For questions as to whether or not a particular reproductive procedure or service is excluded, please contact the Claims Administrator.

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

I. **Cost-Sharing.** The benefits of this paragraph are subject to any applicable Cost-Sharing provisions for similar services.

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

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

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

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

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

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

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

21. **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 for services other than mastectomy prostheses are covered at 90% of the Allowable Expense, after Deductible. In-Network Benefits for mastectomy prostheses 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.

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

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

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

23. **Substance Use Disorder 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 Substance Use Disorders, 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 Substance Use Disorders 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 a Substance Use Disorder 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 $40 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable

Expense, after Deductible.

24. **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 subject to a $40 Copayment.

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

25. **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 subject to a $40 Copayment.

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

26. **Colonoscopies.** The Benefit Plan will provide coverage for diagnostic colonoscopies.

In-Network. In-Network Benefits are covered at 90% of the Allowable Expense, after Deductible.

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

SECTION TEN - ADDITIONAL BENEFITS

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

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

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

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

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

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

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.

You are responsible for any applicable Cost-Sharing provisions under the Benefit Plan for similar services.

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

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

A. Insulin and oral agents for controlling blood sugar (limited to a 30-day supply when purchased at a retail pharmacy, or a 90-day supply when purchased at a mail order pharmacy);

B. Blood glucose monitors;

C. Blood glucose monitors for the visually impaired;

D. Data management systems;

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

F. Injection aids;

G. Cartridges for the visually impaired;

H. Insulin pumps and appurtenances thereto;

I. Insulin infusion devices; and

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

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

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

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

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

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

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

   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.

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.

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; or wigs, 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.

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.

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

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

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

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

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

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

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

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 are subject to a $200 Copayment.

Out-of-Network. Out-of-Network Benefits are subject to a $200 Copayment.

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 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 or air transportation between Facilities when the transport is to the nearest Hospital, Facility or setting in any of the following circumstances:

      (1) From an Out-of-Network Provider Hospital to the nearest In-Network Provider Hospital;

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

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

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

   C. Limitations.

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

      (2) Coverage for air ambulance related to an Emergency Condition or air ambulance related to a non-Emergency Condition is provided when your medical condition is such that transportation by land ambulance is not appropriate; and your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:

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

   In-Network. In-Network Benefits are subject to a $200 Copayment.

   Out-of-Network. Out-of-Network Benefits are subject to a $200 Copayment.

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. The

Benefit Plan will provide coverage for medical visits of Professional Providers who are not employees or interns of the urgent care center.

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

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

8. **Telemedicine Program**

The Benefit Plan provides coverage for telephone consultations, e-mail consultations and online internet consultations between you and providers that participate in the telemedicine program for non-emergent medical conditions. The telemedicine program is provided through MDLIVE. Not all In-Network Providers participate with MDLIVE. For a listing of providers that participate with MDLIVE, you may check the participating provider directory by visiting www.mdlive.com or by contacting MDLIVE, toll free, at 888-632-2738.

Telemedicine is the delivery of healthcare services through the use of privacy compliant technology. It allows you to connect with a provider via video conference, telephone or e-mail for the purposes of diagnosis, consultation and treatment; just as would be provided during a face to face office visit. The telemedicine program is an optional service provided to you and your eligible dependents. To utilize this service, you must register by calling MDLIVE, toll free at 888-632-2738, or by visiting www.mdlive.com. You will need to provide your name, the patient's name (if you are not calling for yourself), the primary Member's and patient's date of birth and zip code.
Common examples of when to use MDLIVE for non-emergent medical care, include, but are not limited to the following:

- Your primary care doctor is not available.
- You are traveling and in need of non-emergent medical care.
- During or after normal business hours, nights, weekends and holidays.
- To request (non-DEA controlled) prescriptions or refills. MDLIVE providers prescribe drugs or medications only if the provider deems it is Medically Necessary.

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

In-Network. In-Network Benefits are subject to a $10 Copayment.

Out-of-Network. OUT-OF-NETWORK BENEFITS ARE NOT COVERED.

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

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

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

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

In-Network. In-Network Benefits are subject to a $25 Copayment for visits to a primary care physician, and a $40 Copayment for visits to a specialist.

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

11. **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 Cost-Sharing provisions for similar services.

12. **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 in accordance with the claim and appeal procedures provisions contained in Section Seventeen.

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

SECTION ELEVEN - EMERGENCY CARE

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

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

   Coverage of Emergency Services or non-Emergency Services for treatment of your Emergency Condition or non-Emergency Condition will be provided regardless of whether the provider is 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 are performed to treat or stabilize your condition in a Hospital.

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

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

Facility:

In-Network. In-Network Benefits are subject to a $200 Copayment.

Out-of-Network. Out-of-Network Benefits are subject to a $200 Copayment.

Professional Provider:

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

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

SECTION TWELVE - HUMAN ORGAN AND STEM CELL (BONE MARROW) TRANSPLANTS

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

1. **Care in Approved Transplant Centers.** Certain types of organ transplant procedures must be performed in transplant centers certified or otherwise approved by the appropriate regulatory authority for the specific type of transplant procedure being performed. The types of organ transplants that must be performed in certified transplant centers are: bone marrow; liver; heart; lung; heart-lung; kidney; and kidney-pancreas. You may contact the Claims Administrator if you wish to obtain a list of certified transplant centers.

2. **No Coverage of Experimental or Investigational Organ Transplants.** The Benefit Plan will not provide coverage for any benefits for organ transplants the Claims Administrator determines to be experimental or investigational. The Claims Administrator maintains and revises from time to time a list of organ transplant procedures that it determines not to be experimental or investigational and that, therefore, are covered under this Benefit Plan. You may contact the Claims Administrator if you have a question concerning whether a particular transplant procedure is covered.

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

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

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

SECTION THIRTEEN – EXCLUSIONS

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

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

2. **Blood Products.** The Benefit Plan will not provide coverage for the cost of blood, blood plasma, other blood products, or blood processing or storage charges, when they are available free of charge in the local area, except the Benefit Plan will provide coverage for blood required for the treatment of hemophilia when billed by a Facility. When not free in the local area, the Benefit Plan will cover blood charges, even if you donate or store your own blood, if billed by a Facility, ambulatory surgery center, or a certified blood bank.

3. **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.

4. **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.

5. **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.

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.

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

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

13. **Free Care.** The Benefit Plan will not provide coverage for any service or care that is furnished to you without charge, or that would have been furnished to you without charge if you were not covered under 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.

14. **Government Hospitals.** Except as otherwise required by law, the Benefit Plan will not provide coverage for any service or care you receive in a Facility or institution which is owned, operated or maintained by: the Veterans Administration (VA); a federal, state, or local government, unless the Facility is an In-Network Provider. However, the Benefit Plan will provide coverage for services or care in such a Facility to treat an Emergency Condition. In this case, the Benefit Plan will continue to provide coverage only for as long as the Claims Administrator determines that emergency care is Medically Necessary and it is not possible for you to be transferred to another Facility.

15. **Government Programs.** The Benefit Plan will not provide coverage for any service or care for which benefits are payable under Medicare or any other federal, state, or local government program, except when required by state or federal law. When you are eligible for Medicare, the Benefit Plan will reduce 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.

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

17. **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.

18. **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.

19. **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 a provider considers the service or care to be Medically Necessary and appropriate.

20. **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.

21. **Private Duty Nursing Service.** The Benefit Plan will not provide coverage for service or care provided by a private duty registered nurse or licensed practical nurse, even if ordered by your physician or licensed health care professional.

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

23. **Reproductive Procedures.** The Benefit Plan will not provide coverage for the following reproductive procedures or services: in vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cloning, sperm banking and donor fees associated with artificial insemination or other procedures, or other procedures or categories of procedures excluded by the Claims Administrator in accordance with its administrative guidelines. For questions as to whether or not a particular reproductive procedure or category of procedure is excluded, please contact the Claims Administrator.

24. **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 telephone consultations provided through the Telemedicine Program described in Section Ten of this booklet), 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 Therapies and Supplies.** The Benefit Plan will not provide coverage for any service or care related to:

    A. Hearing aids, or routine hearing examinations and/or visits for the purpose of prescribing, fitting, servicing, or changing hearing aids; and

B. Vision or hearing therapy, vision training, orthoptics, routine eyewear or routine vision examinations.

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 FOURTEEN - WAITING PERIODS

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

SECTION FIFTEEN - COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION SIXTEEN - TERMINATION OF YOUR COVERAGE

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

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

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

   A. You experience a qualifying event and as a result you choose to terminate your coverage. You must give the Group thirty (30) days' written notice. Your coverage will terminate on the date to which your contributions are paid;

   B. You are no longer a Member of the Group. Your coverage will terminate on the date your employment terminates or you no longer satisfy the eligibility requirements for the Benefit Plan;

   C. You make an intentional misrepresentation of a material fact or commit fraud in applying for coverage or in filing a claim under this Benefit Plan. Your coverage will terminate 30 days from the date notice is provided to you;

   D. On your death or the death of the employee or member of the Group. Your coverage under this Benefit Plan will automatically terminate on the date after your death or the death of the employee or member of the Group;

   E. Termination of the employee or member of the Group's marriage. If the employee or member of the Group becomes divorced, or the employee or member of the Group's marriage is annulled, coverage of the employee or member of the Group's spouse under this Benefit Plan will automatically terminate on the date of the divorce or annulment; or

   F. Termination of coverage of a child. Coverage of an employee or member of the Group's child under this Benefit Plan will terminate on the date the child no longer qualifies under Section Two of this booklet or, if later, the next contributions due date after the Group and/or the Claims Administrator receives notice of termination.

3. **Temporary Continuation of Coverage.** Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer sponsored group health plans must offer employees and their families the

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

SECTION SEVENTEEN - GENERAL PROVISIONS

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

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

3. **Your Medical Records.** In order to provide your coverage under this Benefit Plan, it may be necessary for the Group and/or the Claims Administrator to obtain your medical records and information from Facilities, Professional Providers, Providers of Additional Health Services, and pharmacy who provided services to you. Actions to provide that coverage include processing your claims, reviewing grievances or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you become covered under this Benefit Plan, you automatically give the Group and/or the Claims Administrator permission to obtain and use those records for those purposes.

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

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

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

courts can order you to defend any action the Benefit Plan or Claims Administrator brings against you.

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

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

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

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

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

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

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

    The Benefit Plan will be subrogated to all claims, demands, actions and rights of recovery against any entity including, but not limited to, third parties and insurance

companies and carriers (including your own). The amount of such subrogation will equal the total amount paid under the Benefit Plan arising out of the illness, injury or health condition that is the basis for any claim you (or your estate, legal guardian or legal representative) may have or assert. The Benefit Plan may assert its subrogation rights independently of you or it may choose to assert its reimbursement rights against your recovery.

The Benefit Plan has the right to reimbursement to the extent of benefits paid related to the illness, injury or health condition from any recovery you may receive from these sources regardless of how your recovery is characterized or regardless of whether medical expenses are specifically included in your recovery. The Benefit Plan shall recover the full amount of benefits advanced and paid for the illness, accident, or injury without regard to any claim or fault on 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 Vice President for Administration and Finance of the Group or a person duly authorized in writing by the Vice President for Administration and Finance 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 Vice President for Administration and Finance of the Group or by a person duly authorized in writing by the Vice President for Administration and Finance 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 our list of covered persons, on a monthly basis. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 30 days.

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

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 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 may be payable directly to the Out-of-Network Provider or the Member. Submit claim forms to:

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

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.

> In general, you may not request an external review unless the Claims Administrator has issued a "final adverse determination" of your request for coverage through the internal appeal process. However, if you qualify for an expedited external review, you may also file an expedited external review at the same time as filing an expedited internal appeal. You are also eligible for an external review if both parties have agreed to an external review even though you have not obtained a final adverse determination.
>
> To be eligible for external review, the final adverse determination issued through the first level of the internal appeal process must be based on a determination that the requested service does not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered benefit, or that the requested service is experimental or investigational, or for a rescission of coverage. For purposes of this section a rescission of coverage is a retroactive termination of coverage under the Benefit Plan, except in cases where you fail to pay any required contribution to the cost of coverage under the Benefit Plan. You do not have the right to an external review of any other determinations, even if those other determinations affect your coverage.

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

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

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

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

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

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

Appointment of Authorized Representative
An authorized representative is a person you authorize, in writing, to act on your behalf with respect to a benefit claim and/or appeal a denial of benefits. It also means a person authorized by a court order to submit a benefit claim and/or appeal a denial of benefits on

your behalf. An assignment of benefits by you to a provider will not constitute appointment of that provider as your authorized representative. To appoint an authorized representative, you must complete a form that can be obtained from the Benefit Plan Administrator or the Claims Administrator. However, for a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative without completion of this form.

SUMMARY OF MATERIAL MODIFICATION (SMM)
TO THE
HAMILTON COLLEGE PLAN BENEFITS

This document is intended to notify you of important plan changes to the Hamilton College Plan Benefits (the "Plan") to comply with the Families First Coronavirus Response Act; the Coronavirus Aid, Relief and Economic Security (CARES) Act; guidance issued by the Department of Labor and IRS regarding the Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak; and certain provision of New York Department of Financial Services Emergency Regulations**,** which are effective as of the dates set forth below. This SMM supplements the January 1, 2019 Plan booklet ("Booklet") that is part of the Hamilton College Plan Benefits Summary Plan Description ("SPD").

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1. Effective as of March 16, 2020, and for 90 days thereafter (unless extended by future regulations or guidance), the Plan will provide coverage for all telehealth when rendered by a participating provider or non-participating provider without cost-sharing. If your Plan provides coverage for telehealth through a telehealth vendor, such as MDLive, such coverage will also be provided without cost-sharing.

2. Effective as of March 13, 2020, 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)), the 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 Plan will provide coverage for any items and services provided during an office visit (including telehealth), urgent care center visit, or emergency room visit that relates to the furnishing or administration of the test or to the evaluation of the individual for purposes of determining the need for the test; and results in an order for or administration of such test. Such coverage will be provided when rendered by a participating provider or non-participating provider

and will not be subject to any cost-sharing (i.e. coinsurance, copayments or deductibles), prior authorization requirements or any other medical management requirements.

3. Effective as of 15 business days after a recommendation is made from the U.S. Prevention Services Task Force or CDC Advisory Committee on Immunization Practices, the Plan will provide coverage for vaccines and other services intended to prevent COVID-19 when rendered by a participating provider, without cost-sharing.

4. Effective as of March 20, 2020, the Plan will suspend, for 90 days (unless it is extended by future regulations or guidance), any:

   (a) preauthorization requirements that may apply to schedule surgeries or admissions at a Hospital;
   (b) concurrent review for inpatient Hospital services;
   (c) retrospective review for inpatient Hospital services and Emergency Services rendered by a participating provider; and
   (d) preauthorization requirements for home health care and inpatient rehabilitation services following an inpatient Hospital stay.

5. Effective as of April 22, 2020, the Plan will suspend until June 18, 2020 (unless it is extended by future regulations or guidance), any:

   (a) preauthorization requirements for all services provided at a Hospital;
   (b) concurrent review for all services provided at a Hospital;
   (c) retrospective review for all services provided at a Hospital.

   However, the Plan reserves the right to retrospectively review services provided at a Hospital upon the expiration of this provision if it has evidence that a Hospital is engaging in fraudulent or abusive billing practices. In the event this provision is extended by future regulations or guidance, the Plan is automatically amended to comply.

6. Effective for dates of service January 31, 2020 through and including September 7, 2020 (or such other date that may be communicated in the future by the Plan), the Plan will provide coverage for all services related to the treatment of COVID-19 (inpatient, outpatient or otherwise), if such services are otherwise covered under the Plan. Such coverage will be provided when rendered by a participating provider or non-participating provider and will not be subject to any cost-sharing (i.e. coinsurance, copayments or deductibles), prior authorization requirements or any other medical management requirements.

7. The allowed amount for any services described in this SMM that are rendered by a non-participating provider (other than diagnostic testing) will be the non-participating provider's charge. However, the Plan reserves the right to negotiate a lower rate with non-participating providers or to pay a Blue Cross and/or Blue Shield host plan's rate, if lower. The allowed amount for diagnostic testing will be the non-participating provider's publicly listed price for such test.

8. Effective as of May 2, 2020, and for 90 days thereafter (unless extended by future regulations or guidance), the Plan will provide coverage for all outpatient mental health visits for an Essential Worker, without Cost-Sharing, when rendered by a Participating Provider. If the Plan provides coverage under a high deductible health plan, the Deductible will continue to apply.

For purposes of the section, an Essential Worker is someone who is, or was, during the state of emergency that began on March 7,2020, employed as a health care worker, first responder, or in any position within a nursing home, long-term care Facility, or other congregate care setting; or any other individual who directly interacted with the public while working, including:

(a) correction/parole/probation officers;
(b) direct care providers;
(c) firefighters;
(d) health care practitioners, professionals, aides, and support staff (e.g. physicians, nurses, and public health personnel);
(e) medical specialists;
(f) nutritionists and dietitians;
(g) occupational/physical/recreational/speech therapists;
(h) paramedics/emergency medical technicians;
(i) police officers;
(j) psychologists/psychiatrists;
(k) residential care program managers;
(l) animal care workers (e.g., veterinarians);
(m) automotive service and repair workers;
(n) bank tellers and other bank workers;
(o) building code enforcement officers;
(p) childcare workers;
(q) client-facing case managers and coordinators;
(r) counselors (e.g., mental health, addiction, youth, vocational, and crisis);
(s) delivery workers;
(t) dentists and dental hygienists;
(u) essential construction workers at occupied residences or buildings;
(v) faith-based leaders (e.g., chaplains and clergy members);
(w) field investigators/regulators for health and safety;
(x) food service workers;
(y) funeral home workers;
(z) hotel/motel workers;
(aa) human services providers;
(bb) laundry and dry-cleaning workers;
(cc) mail and shipping workers;
(dd) maintenance and janitorial/cleaning workers;
(ee) optometrists, opticians, and supporting staff;
(ff) retail workers at essential businesses (e.g., grocery stores, pharmacies,
(gg) convenience stores, gas stations, and hardware stores);
(hh) security guards and personnel;
(ii) shelter workers and homeless support staff;
(jj) social workers;
(kk) teachers/professors/educators;
(ll) transit workers (e.g., airports, railways, buses, and for-hire vehicles);
(mm) trash and recycling workers; and
(nn) utility workers

9. Effective as of March 1, 2020, the 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 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 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 covered person 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 will be disregarded and (iii) the special enrollment period will end 16 days after the end of the Outbreak Period.

Coverage with respect to (b) and (d) above, may be retroactive to the date of the qualifying event; provided the covered person 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 March 1, 2020 and ending 60 days after the announced end of the “National Emergency” described in the next sentence (or on a different date announced by the Internal Revenue Service and the Employee Benefits Security Administration (the “Agencies”)) and will be interpreted to be consistent with the meaning of that term under the Notice issued by the Agencies and published in the Federal Register on May 4, 2020. The “National Emergency” for this purpose is the National Emergency declared on March 13, 2020 (with a March 1, 2020 effective date) as a result of the COVID-19 outbreak. If the National Emergency is determined by the Agencies to end on different dates in different parts of the country, the Outbreak Period will be interpreted to end on the date that is determined by the Plan Administrator to be appropriate for the Plan.

If you have questions about these Plan changes, this SMM, or your SPD, please contact the Plan Administrator.

SUMMARY OF MATERIAL MODIFICATION (SMM)
TO THE
HAMILTON COLLEGE PLAN

This document is intended to notify you of important plan changes to the Hamilton College Plan (the "Plan") to comply with the consumer protections of Division BB of the Consolidated Appropriations Act, 2021 (the "Act") and to make certain other changes as described herein, effective as of January 1, 2022 (unless otherwise stated herein). The provisions of this document are intended to help provide for the Plan's good faith compliance with applicable requirements of the Act and, in cfailurease of any ambiguity between the provisions of this document and the requirements of the Act, shall be interpreted to be consistent with the requirements of the Act. This SMM supplements the January 1, 2019 Plan booklet ("Booklet") that is part of the Hamilton College Plan Summary Plan Description ("SPD").

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1. The ***"Allowable Expense"*** definition under the ***"Introduction and Definitions"*** section is deleted and replaced with the following:

Allowable Expense. The maximum amount the Benefit Plan will pay for the services or supplies covered under this Benefit Plan, before any applicable Cost-Sharing amounts are subtracted. The Allowable Expense is determined as follows:

The Allowable Expense for In-Network Providers 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, or the In-Network Provider's charge, if less. However, when the In-Network Provider's charge is less than the amount the Benefit Plan has negotiated with the In-Network Provider, your Cost-Sharing amount will be based on the In-Network Provider's charge.

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 an amount based on the In-Network Provider's negotiated rate, or the Facility's charge, if less.

(2) **Facilities outside the Service Area.**
For Facilities outside the Service Area, the Allowable Expense will be an amount based on the In-Network Provider's negotiated rate, or the Facility's charge, if less.

(3) **For a Professional Provider or a Provider of Additional Health Services in the Service Area (other than for Ground Ambulance or Emergency Services).**
For a Professional Provider or a Provider of Additional Health Services in the Service Area, the Allowable Expense will be an amount based on the In-Network Provider's negotiated rate, or the Professional Provider or Provider of Additional Health Services' charge, if less.

(4) **For a Professional Provider or a Provider of Additional Health Services Outside the Service Area (other than for Ground Ambulance or Emergency Services).**
For a Professional Provider or a Provider of Additional Health Services outside the Service Area, the Allowable Expense will be the 90th percentile of the Usual, Customary and Reasonable ("UCR") rate or charge, as supplied by Fair Health, or the Professional Provider or Provider of Additional Health Services' charge, if less.

(5) **Ground Ambulance.** The Allowable Expense for an Out-of-Network Provider for ground ambulance, other than for ground ambulance that is determined to be a surprise bill (see below), will be the Out-of-Network Provider's charge.

(6) **Surprise Bills.** The Allowable Expense for surprise bills for an Out-of-Network Provide 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.

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

The 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.

The 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.

2. A new definition of **"*Cost-Sharing"*** is added alphabetically under the ***"Introduction and Definitions"*** section to read as follows:

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

3. The **"*Emergency Services"*** definition under the **"*Introduction and Definitions"*** section is amended to read as follows:

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.

4. A new definition of **"*Independent Freestanding Emergency Department"*** is added alphabetically under the **"*Introduction and Definitions"*** section to read as follows:

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

5. A new section entitled "***Protection from Surprise Bills"*** is added to read as follows:

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 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 an 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 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 Plan's normal reimbursement rules.

For any surprise bills, the 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 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 Plan will comply with the additional or modified requirements as required by such guidance.

6. **Air Ambulance.** To the extent your Plan provides coverage for air ambulance or Emergency Services for an Emergency Condition and the Cost-Sharing applied to such air ambulance services or Emergency Services when rendered by an Out-of-Network Provider is different than the Cost-Sharing applied when such services are rendered by an In-Network Provider, to the extent necessary to comply with the No Surprises Act, the Plan is amended to apply the same Cost-Sharing to air ambulance services or Emergency Services for an Emergency Condition when rendered by an Out-of-Network Provider as the Cost-Sharing that is applied to such services when rendered by an In-Network Provider.

7. The definition of ***"In-Network Provider"*** under the ***"Introduction and Definitions"*** section is revised to read as follows:

   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 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.

8. A new section entitled ***"Transitional Care"*** is added to read as follows:

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 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 Plan with necessary medical information related to your care and adhere to any policies and procedures established by the Plan, including those for assuring quality of care and obtaining preauthorization and a treatment plan approved by the 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 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 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 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.

9. The **"*Claim and Appeal Procedures"*** subsection of the **"*General Provisions"*** section is revised as follows:

a) The following is added to the ***"Claim and Appeal Procedures"*** section to replace the sentence that begins with "Payments for services rendered by an Out-of-Network Provider":

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 Employee. 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 Plan will be made directly to the Out-of-Network Provider.

b) You have a right to external review for situations in that a involve consideration of whether the plan is complying with the surprise billing and cost-sharing protections of the No Surprises Act. As such, the **"*External Review"*** subsection under the **"*Claim and Appeals Procedure"*** section is revised to extend the right to external review in this situation. In addition, the **"*Coverage Determinations Subject to External Review"*** subsection is revised to read as follows:

Coverage Determinations Subject to External Review. This subparagraph describes the general conditions for external review.

In general, you may not request an external review unless the 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 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 Plan's wellness program (if any); or
vi. involving whether the 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 Plan, except in cases where you fail to pay any required contribution to the cost of coverage under the Plan. You do not have the right to an external review of any other determinations, even if those other determinations affect your coverage.

10. The ***"Temporary Tolling of Certain Timeframes"*** provision is revised to read as follows:

TEMPORARY TOLLING OF CERTAIN TIMEFRAMES

Effective as of March 1, 2020, the 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 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 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 covered person has to act after the end of the Outbreak Period. For example, for a special enrollment request that is subject to a 30-day special enrollment period, if the special enrollment period started on February 15, 2020, (i) the period from February 15 through February 29 will count as the first 14 days of the 30-day period (leaving 16 days in the special enrollment period), (ii) the entire Outbreak Period (March 1, 2020 through February 28, 2021) will be disregarded and (iii) the special enrollment period will end 16 days after the end of the Outbreak Period, on March 16, 2021.

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

For purposes of this section, the “Outbreak Period” is the period beginning on the later of (1) March 1, 2020 or (2) the “Applicable Event Date” (as defined below) and ending on the earlier of (A) one year from the Applicable Event Date or (B) 60 days after the announced end of the “National Emergency” described in the next sentence (or on a different date announced by the Internal Revenue Service and the Employee Benefits Security Administration (the “Agencies”)) and will be

interpreted to be consistent with the meaning of that term under the Notice issued by the Agencies and published in the Federal Register on May 4, 2020 (and any subsequent guidance from the Agencies). The "National Emergency" for this purpose is the National Emergency declared on March 13, 2020 (with a March 1, 2020 effective date) as a result of the COVID-19 outbreak. If the National Emergency is determined by the Agencies to end on different dates in different parts of the country, the Outbreak Period with respect to a specific event or all events, if applicable, will be interpreted to end on the date that is determined by the Plan Administrator to be appropriate for the Plan. In no case will the Outbreak Period for any event last longer than one year or begin before March 1, 2020 or after the date described in (B) above.

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

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

11. The **"*Medical Necessity and Prior Approval"*** section is revised as follows:

a) The **"*Care Must Be Medically Necessary"*** subsection is renamed **"*Medical Necessity"*** and revised to read as follows:

Medical Necessity.
Coverage will be provided under the 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 Plan has to provide coverage for it. The 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 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.

b) ***"Utilization Review"*** and ***"Medical Management"*** subsections are added to read as follows:

Utilization Review.
The 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 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 Plan send you electronic notification of a utilization review determination instead of notice in writing or by telephone. You must tell the 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.

Medical Management.
The benefits available to you under the 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 Plan. Services must be Medically Necessary for benefits to be covered under the Plan.

12. The ***"General Exclusions"*** section is amended by adding the following ***"COVID-19 Testing"*** exclusion thereunder:

COVID-19 Testing. Notwithstanding any provision of the Plan to the contrary, the Plan does not include coverage for COVID-19 testing in any circumstance where (1) the 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.

13. The **"*Government Hospitals"*** exclusion under the **"*General Exclusions"*** section is revised to read as follows:

    Government Hospitals. Except as otherwise required by law (or specifically identified as being covered elsewhere in this Plan), the Plan will not provide coverage for care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, unless you are taken to the Hospital because it is close to the place where you were injured or became ill and Emergency Services are provided to treat your Emergency Condition.

If you have questions about these Plan changes, this SMM, your Booklet, or SPD please contact the Plan Administrator.