Dear Subscriber:

Welcome to Excellus BlueCross BlueShield.

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

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

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

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

Excellus BluePPO
PREFERRED PROVIDER ORGANIZATION CERTIFICATE OF COVERAGE
Issued by
EXCELLUS HEALTH PLAN, INC.

A Nonprofit Independent Licensee of the BlueCross BlueShield Association

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

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

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

Out-of-Network Benefits. The Out-of-Network Benefits portion of this Certificate covers health care services described in this Certificate 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. You will be responsible for meeting an annual Deductible and paying a Coinsurance amount, as well as for paying any difference between the Allowable Expense and the provider’s charge.

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

EXCELLUS HEALTH PLAN, INC.
doing business as
Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: Christopher C. Booth
President and Chief Executive Officer
<table>
<thead>
<tr>
<th>SECTION</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONE - INTRODUCTION AND DEFINITIONS</td>
<td>3</td>
</tr>
<tr>
<td>TWO - WHO IS COVERED</td>
<td>5</td>
</tr>
<tr>
<td>THREE - MEDICAL NECESSITY AND PRIOR APPROVAL</td>
<td>7</td>
</tr>
<tr>
<td>FOUR - COST SHARING EXPENSES</td>
<td>9</td>
</tr>
<tr>
<td>FIVE - INPATIENT CARE</td>
<td>9</td>
</tr>
<tr>
<td>SIX - OUTPATIENT HOSPITAL CARE</td>
<td>10</td>
</tr>
<tr>
<td>SEVEN - HOME CARE</td>
<td>12</td>
</tr>
<tr>
<td>EIGHT - HOSPICE CARE</td>
<td>13</td>
</tr>
<tr>
<td>NINE - PROFESSIONAL SERVICES</td>
<td>14</td>
</tr>
<tr>
<td>TEN - ADDITIONAL BENEFITS</td>
<td>20</td>
</tr>
<tr>
<td>ELEVEN - EMERGENCY CARE</td>
<td>22</td>
</tr>
<tr>
<td>TWELVE - HUMAN ORGAN AND BONE MARROW TRANSPLANTS</td>
<td>23</td>
</tr>
<tr>
<td>THIRTEEN - EXCLUSIONS</td>
<td>23</td>
</tr>
<tr>
<td>FOURTEEN - WAITING PERIODS</td>
<td>28</td>
</tr>
<tr>
<td>FIFTEEN - COORDINATION OF BENEFITS</td>
<td>29</td>
</tr>
<tr>
<td>SIXTEEN - TERMINATION OF YOUR COVERAGE</td>
<td>30</td>
</tr>
<tr>
<td>SEVENTEEN - RIGHT TO NEW CONTRACT AFTER TERMINATION</td>
<td>33</td>
</tr>
<tr>
<td>EIGHTEEN - GENERAL PROVISIONS</td>
<td>34</td>
</tr>
</tbody>
</table>
SECTION ONE - INTRODUCTION AND DEFINITIONS

1. Your Coverage Under This Certificate. Your employer or organization (referred to as the "group contract holder") has purchased a group health insurance contract from us. Under that contract we will provide the benefits described in this Certificate to members of the group, that is, to employees of the employer or to members of the organization and their covered dependents. However, this Certificate is not a contract between you and us. You should keep this Certificate with your other important papers so that it is available for your future reference.

2. Definitions.

A. Allowable Expense. "Allowable Expense" means the maximum amount we will pay to a Facility, Professional Provider or Provider of Additional Health Services for the services or supplies covered under this Certificate, before any applicable Deductible, Copayment and Coinsurance amounts are subtracted. We determine our Allowable Expense as follows:

1. The Allowable Expense for covered services received from a Facility is the amount set by state or federal law. In the absence of state or federal law, the Allowable Expense will be the lowest of: the amount we have negotiated with the Facility; the amount approved by another Blue Cross and Blue Shield Plan; or the average amount we have negotiated with our Facilities that are In-Network Providers of the same type as the Facility (or the Facility’s charge, if less).

2. Our Board of Directors sets the payment policy for services rendered by a Professional Provider or a Provider of Additional Health Services. Every service or procedure performed by a Professional Provider or a Provider of Additional Health Services is assigned an amount that our Board of Directors determines is appropriate. The Allowable Expense for covered services performed by a Professional Provider or a Provider of Additional Health Services will be the lowest of: the amount we have negotiated with the Professional Provider or the Provider of Additional Health Services; the amount set by our Board of Directors, less any applicable discount; the amount approved by another Blue Cross and Blue Shield Plan; or the average amount we have negotiated with Professional Providers or Providers of Additional Health Services who are In-Network Providers of the same type as the Professional Provider or Provider of Additional Health Services performing the service (or the Professional Provider or Provider or Additional Health Services’ charge, if less).

The Allowable Expense for Out-of-Network Professional Providers and Out-of-Network Providers of Additional Health Services outside of our Service Area is the lower of the usual and customary charge or the Professional Provider or Provider of Additional Health Service’s charge. The usual and customary charge is a fee or charge we determine based on charge data that we collect from recognized sources for the geographic region in which the particular service at issue was provided.

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

C. Coinsurance. A charge, expressed as a percentage of the Allowable Expense, which you must pay for certain services covered under this Certificate. You are responsible for the payment of any Coinsurance directly to the provider.

D. Copayment. A charge, expressed as a fixed dollar amount, which you must pay for certain health services covered under this Certificate. You are responsible for the payment of any Copayments directly to In-Network Providers when you receive health services.

E. Deductible. A charge, expressed as a fixed dollar amount, which you must pay once each Calendar Year before we will pay anything for certain Out-of-Network Benefits covered under this Certificate during that Calendar Year. (There are special Deductible rules when you have other than individual coverage. See Section Four.)

F. Effective Date. The date your coverage under this Certificate begins. Coverage begins 12:01 a.m. on the Effective Date.
G. **Facility.** A Hospital; ambulatory surgery facility; birth center; dialysis center; rehabilitation facility; Skilled Nursing Facility; hospice; home health agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; an institutional provider of mental health or chemical dependence and abuse treatment operating under Article 31 of the New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or other provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable). If you receive treatment outside of New York State, the Facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations to provide a chemical abuse treatment program.

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

1. Inpatient diagnostic and therapeutic services for surgical and medical diagnosis;
2. Treatment and care of injured and sick persons by or under the supervision of physicians; and
3. Twenty-four (24) hour nursing service by or under the supervision of registered nurses.

None of the following are considered Hospitals:

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

I. **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.

J. **In-Network Provider.** A Facility, Professional Provider or Provider of Additional Health Services that has a PPO provider agreement with us or any other Blue Cross and/or Blue Shield Plan to provide health services to Members. We have provider directories that list all of our In-Network Providers. Copies of the directory are issued on enrollment and are available free of charge upon request.

K. **Medical Director.** The person designated by us to monitor quality of care and appropriate utilization of health services.

L. **Medical Necessity.** See Section Three.

M. **Member.** Any Subscriber or eligible dependent who meets all applicable eligibility requirements and for whom the required premium payment has actually been received by us.

N. **Out-of-Network Benefits.** The Out-of-Network Benefits portion of this Certificate covers health care services described in this Certificate 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. You will be responsible for meeting an annual Deductible and for paying a Coinsurance amount as well as paying any difference between the Allowable Expense and the provider’s charge.

O. **Out-of-Network Provider.** A Facility, Professional Provider or Provider of Additional Health Services that does not have a PPO provider agreement with us or any other Blue Cross and/or Blue Shield Plan to provide health services to Members.

P. **Preferred Provider Organization (PPO).** A network of Facilities, Professional Providers and Providers of Additional Health Services that have PPO provider agreements with us or another Blue Cross and/or Blue Shield Plan to provide health services to Members.
Q. **Professional Provider.** A certified and licensed physician; osteopath; dentist; optometrist; chiropractor; registered psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; licensed midwife; speech-language pathologist; audiologist; or any other licensed health care provider that the New York State Insurance Law requires to be recognized who charges and bills patients for services. Professional Provider’s services must be rendered within the lawful scope of practice for that type of provider in order to be covered under this Certificate.

R. **Provider of Additional Health Services.** A provider of services or supplies covered under this Certificate (such as diabetic equipment and supplies or ambulance service) 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 us for payment under this Certificate.

S. **Service Area.** Our Service Area consists of Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Oswego; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; Jefferson counties.

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

U. **Skilled Nursing Facility.** A facility accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or qualified as a Skilled Nursing Facility under Medicare. We will provide coverage for your care in a Skilled Nursing Facility only if we determine, in our sole judgement, that the care is Skilled Care.

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

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

### SECTION TWO - WHO IS COVERED

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

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

2. **Other Children Covered Under This Certificate.** In addition to your natural children, the following other children may also be covered under this Certificate if the child meets the above eligibility requirements for children covered under this Certificate:
   A. a legally adopted child;
   B. a child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order;
   C. a stepchild who is chiefly dependent upon you for support; and
3. **Newborn Child.** If you have a type of coverage that would cover a newborn, your newborn child will be covered at birth, provided you notify us within 30 days of the birth by completing the enrollment form to add the child to your coverage. If you are changing your type of coverage (for example from individual to family coverage) in order to cover the newborn child, you must complete the enrollment form to extend your coverage to include your child within 30 days of the birth. If you do not complete the form within 30 days of the birth, coverage of the child will not become effective until the next premium due date after we receive the application. If a child of yours who is covered under this Certificate gives birth, your newborn grandchild will not be covered (unless any of the criteria of Paragraph 2 above apply).

4. **Adopted Newborns.** If you have a type of coverage that will cover a newborn, your newborn child will be covered at birth, provided you notify us within 30 days of the birth by completing the enrollment form to add the child to your coverage. If you are changing your type of coverage (for example from individual to family coverage) in order to cover the adopted newborn, you must complete the enrollment form to extend your coverage to include your child within 30 days of the birth. If you do not complete the form within 30 days of the birth, coverage of the child will not become effective until the next premium due date after we receive the application. If a child of yours who is covered under this Certificate gives birth, your newborn grandchild will not be covered (unless any of the criteria of Paragraph 2 above apply).

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

   A. **Family Coverage -** If family coverage applies, then you, the Subscriber, and your spouse and your children as described above are covered;

   B. **Spousal Coverage -** If spousal coverage applies, then only you, the Subscriber, and your spouse as described above are covered;

   C. **Child Coverage -** If child coverage applies, then you, the Subscriber, and your child or children as described above are covered;

   D. **Two-Person Coverage -** If two-person coverage applies, then you, the Subscriber, and your spouse or one child as described above are covered. You may only select two-person coverage if your family unit consists of two people.

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

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

   A. If you, the Subscriber, elect coverage before becoming eligible for coverage or within 30 days of becoming eligible, coverage begins at 12:01 a.m. on the date determined by your group;

   B. If you, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible, you must wait until the group’s open enrollment period, except as provided in Paragraph 7 below. Coverage then begins at 12:01 a.m. on the next premium due date after the next open enrollment period; or

   C. If you, the Subscriber, marry while covered, and we receive notice of such marriage within 30 days thereafter, coverage for the spouse starts at 12:01 a.m. on the date of such marriage; otherwise coverage for the spouse will start at 12:01 a.m. on the next premium due date after the next open enrollment period.

7. **When You Reject Initial Enrollment, But Do Not Need to Wait Until the Group’s Open Enrollment Period to Enroll for Coverage.** If you, the Subscriber, reject initial enrollment under this Certificate, you may enroll for coverage if all of the following conditions are met:

   A. You were covered under another plan or contract when coverage was initially offered;

   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 lost eligibility for one or more of the following reasons:
(1) termination of employment;
(2) termination of the other plan or contract;
(3) death of the spouse;
(4) legal separation, divorce or annulment;
(5) reduction in the number of hours worked;
or
(6) the employer or other group ceased its contribution toward the premium for the other plan or contract.

C. You apply for coverage under this Certificate within 30 days after termination for one of the reasons set forth in Subparagraph B above.

If you enroll for coverage pursuant to this paragraph, your coverage will begin at 12:01 a.m. on the date of the loss of coverage.

8. Notification of Change in Your Coverage.

A. To Add a Spouse or Child. If you need to add a spouse or child to your coverage, you must complete and return to us a form for this purpose and any requested documentation. The addition of a spouse or child will be effective as of the date of marriage, birth or adoption or other event making the child eligible for coverage under Paragraph 2, if you return to us a completed application and requested documents within 30 days of the wedding, birth or adoption or other event and the applicable premium is paid. If you do not return a completed form and documentation within 30 days, your spouse or child will be added to your coverage as of the next premium due date after the next open enrollment period, so long as the applicable premium is paid.

B. When Coverage of a Spouse or Child Terminates. If you have other than individual coverage you should notify us of any event that affects your coverage, such as, your divorce, the death of your spouse, Medicare eligibility or a child marrying, leaving school, reaching the age at which coverage terminates or otherwise experiencing an event which would normally result in termination of dependent coverage. We will provide you with a form for that purpose. If such change results in your seeking a different type of coverage at a lower premium (such as a switch to individual coverage), the form and requested documentation must be returned within 30 days of the event in order for the change in premium to be effective on the date of the event. If you do not return a completed form and any requested documentation within 30 days of the event, the change in premium will be effective as of the next premium due date after they are received.

Nothing in this Subparagraph B is designed to affect the provisions of Section Sixteen governing terminations of coverage. This Subparagraph B only involves the effective date of changes in premiums 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 us of the reasons for the continuation of the coverage, on a form provided by us to you for that purpose, together with any requested documentation, no later than 60 days after the date dependent coverage would usually terminate.

SECTION THREE - MEDICAL NECESSITY AND PRIOR APPROVAL

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

We will decide whether care was Medically Necessary. We will base our decision in part on a review of your medical records. We will also evaluate medical opinions we receive. This could include the medical opinion of a professional society, peer review committee or other groups of physicians.

In determining if a Service is Medically Necessary, we will also consider:

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

A. they are appropriate and consistent with the diagnosis and treatment of your medical condition;
B. they are required for the direct care and treatment or management of that condition;
C. if not provided, your condition would be adversely affected;
D. they are provided in accordance with community standards of good medical practice;
E. they are not primarily for the convenience of you, your family, the Professional Provider or another provider;
F. they are the most appropriate service and rendered in the most efficient and economical way and at the most economical level of care which can safely be provided to you; and
G. when you are an inpatient, your medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided to you in any other setting (e.g., outpatient, physician's office or at home).

2. Service or Care Must Be Approved Standard Treatment. Except as otherwise required by law, no service or care rendered to you will be considered Medically Necessary unless we determine, in our sole judgment, the service or care is consistent with the diagnosis and treatment of your medical condition; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative. Please see Section Eighteen, paragraph 32 for your right to an external appeal of our determination that service or care is not Medically Necessary.

3. Services Subject to Prior Approval. Our prior approval is required before you receive certain services covered under this Certificate. The services subject to prior approval are:

A. all services relating to organ transplants;
B. all In-Network Benefits and Out-of-Network Benefits for home care services;
C. all In-Network Benefits and Out-of-Network Benefits for inpatient admissions, excluding maternity admissions;
D. all In-Network Benefits and Out-of-Network Benefits for infusion therapy;
E. all In-Network Benefits and Out-of-Network Benefits for magnetic resonance imaging (“MRI”) procedures;
F. all In-Network Benefits and Out-of-Network Benefits for CAT scans;
G. all In-Network Benefits and Out-of-Network Benefits for PET scans; and
H. all In-Network Benefits and Out-of-Network Benefits for hospice care.

4. Prior Approval Procedure. Members who seek coverage for the services listed in Paragraph 3 above must call us at the number indicated on their identification card to have the care pre-approved. We request 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 us within 24 hours after your admission or as soon thereafter as reasonably possible. However, you must call us 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, we will review the reasons for your planned treatment and determine if benefits are available. We will notify you and your Professional Provider of our decision by telephone and in writing within three business days of receipt of all necessary information. If your treatment involves continued or extended health care services, or additional services for a course of continued treatment, we 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 our decision you may appeal by following the appeal procedures set forth in Section Eighteen, paragraph 31. Any written appeals must be made to: 165 Court Street, Rochester, New York 14647.

6. Failure to Seek Approval. If you fail to seek our prior approval for benefits subject to this Section, we will pay an amount $500 less than we would otherwise have paid for the care, or we will pay only 50% of the amount we would otherwise have paid for the care, whichever results in a greater benefit for you. You must pay the remaining charges. We will pay the amount specified above only if we determine the care was Medically Necessary even though you did not seek our prior approval. If we determine, in our sole judgment, that the services were not Medically Necessary, you will be responsible for paying the entire charge for the service.
SECTION FOUR - COST SHARING EXPENSES

1. **Copayments.** The Copayments you must pay for covered services when you are entitled to In-Network and Out-of-Network Benefits are set forth in the section where the particular service is described.

2. **Deductible.** Except where stated otherwise, each person covered under this Certificate must pay the first $750 of Allowable Expenses incurred for Out-of-Network services under this Certificate during each Calendar Year. If you have other than individual coverage, the Deductible applies to each person covered under this Certificate. However, after Deductible payments for any and all persons covered under this Certificate total $2,250 in a Calendar Year, no further Deductible will be required for any person covered under this Certificate for that Calendar Year. No more than $750 of any person’s Allowable Expenses can be applied to the maximum limit of $2,250.

3. **Coinsurance.** Except where stated otherwise, after you have satisfied the annual Deductible, you will be responsible for a percentage of the Allowable Expense. The Coinsurance amounts you must pay are set forth in the section where the particular service is described.

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

5. **Maximum Deductible and Coinsurance Amounts.** When you have expended $2,000 Out-of-Network Deductibles and Coinsurance in any Calendar Year, we will provide coverage for 100% of the Allowable Expense for Out-of-Network Benefits for the remainder of the Calendar Year. If other than individual coverage applies, when members of the same family covered under this Certificate have paid an aggregate of $6,000 in any Calendar Year in payment of Deductibles and Coinsurance, we will provide coverage for 100% of the Allowable Expense for the balance of the Calendar Year; however, no individual family member will have to expend more than $2,000 in Deductibles and Coinsurance in any Calendar Year. You will remain responsible for any charges of an Out-of-Network Provider that are in excess of the Allowable Expense.

SECTION FIVE - INPATIENT CARE

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

2. **Services Not Covered.** We will not provide coverage for:
   
   A. Additional charges for special duty nurses;
   
   B. Private room, unless in our sole judgment, it is Medically Necessary for you to occupy a private room. If you occupy a private room in a Facility and we determine that a private room is not Medically Necessary, our coverage will be based upon the Facility’s maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room;
   
   C. Blood, except we will provide coverage for blood required for the treatment of hemophilia. However, we will provide coverage for blood and blood products when participation in a voluntary blood replacement program is not available to you;
   
   D. Non-medical items, such as telephone or television rental;
   
   E. Medications, supplies, and equipment which you take home from the Facility; or
   
   F. Custodial care. (See Section Thirteen, paragraph 8)

3. **Conditions for Inpatient Care; Limitations on Number of Days of Care.** Inpatient Facility care is subject to the following conditions and limitations:
   
   A. **Inpatient Hospital Care.** We will provide coverage when you are required to stay in a Hospital for acute medical or surgical care and are not admitted to the Hospital for mental health care or for diagnosis and treatment of chemical dependence and/or abuse. (See Subparagraphs B, C and D below for limitations and exclusions on our coverage for mental health care, diagnosis and treatment of chemical dependence and abuse and Skilled Nursing Facility care.)
   
   B. **Mental Health Care.** We will not provide coverage for hospitalization that is for mental health care, coverage for care in a licensed night or day care program for mental health care, or coverage for care in a residential treatment facility.
C. **Inpatient Detoxification.** We will not provide coverage for active treatment for detoxification needed because of chemical dependence.

D. **Skilled Nursing Facility.** We will provide coverage for care in a Skilled Nursing Facility if we determine that hospitalization would otherwise be Medically Necessary for the care of your condition, illness or injury for up to 120 days in a Calendar Year.

In-Network Benefits and Out-of-Network Benefits for Skilled Nursing Facility care will both be counted toward your annual limit.

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

F. **Inpatient Chemical Dependence and Abuse Rehabilitation.** We will not provide coverage for active treatment for rehabilitation upon a diagnosis of chemical dependence and abuse.

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

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

6. **Infertility Treatment Services.** We will provide coverage for Medically Necessary inpatient Hospital care in connection with infertility treatment services provided by a Professional Provider pursuant to Section Nine, paragraph 19.

7. **Payments for Inpatient Care.**

   **In-Network.** In-Network Benefits for Inpatient Hospital Care and Physical Rehabilitation are subject to a $100 Copayment per Single Confinement. A Single Confinement means one or more inpatient admissions to a Facility. When you are admitted to a Facility after at least 90 days during which you have not been confined for the same condition in any Facility, you will begin a new Single Confinement.

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

**SECTION SIX - OUTPATIENT CARE**

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

1. **Care in Connection with Surgery.** We will only provide coverage if we determine, in our sole judgment, that it was necessary to use the Facility to perform the surgery.

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

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

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

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

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

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

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

   **In-Network.** In-Network Benefits are covered in full.
3. Diagnostic Procedures. We will provide coverage for diagnostic procedures, including x-rays and laboratory procedures.

   In-Network. In-Network Benefits for diagnostic x-ray and imaging services are subject to a $20 Copayment. All other diagnostic procedures are covered in full.

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

4. Radiation Therapy and Chemotherapy. We will provide coverage for radiation therapy and chemotherapy.

   In-Network. In-Network Benefits are covered in full.

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

5. Hemodialysis. We will provide coverage for hemodialysis treatments of an acute or chronic kidney ailment.

   In-Network. In-Network Benefits are covered in full.

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

6. Mammography Screenings. We will provide coverage for mammography screenings for occult breast cancer. The screenings may be provided in the outpatient department of a Facility under this Section or in a Professional Provider’s office pursuant to Section Nine, paragraph 12. Our coverage for routine mammography screenings under this Section and Section Nine, paragraph 12 are subject to the following aggregate limitations:

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

   B. Women 35 Through 39 Years of Age. We will provide coverage for one baseline mammogram for women 35 through 39 years of age.

   C. Women 40 Years of Age or Older. We will provide coverage for one mammogram in each Calendar Year for women 40 years of age and older.

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

   In-Network. In-Network Benefits are covered in full.

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

7. Cervical Cytology Screenings (Pap Smears). We will provide coverage for one screening for cervical cancer and its precursor states each Calendar Year for women 18 years of age or older. The screening may be provided in the outpatient department of a Facility under this Section or in a Professional Provider’s office pursuant to Section Nine, paragraph 13. Our coverage under this Section and Section Nine are subject to the visit limit above. Cervical cytology screening shall mean a pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

   In-Network. In-Network Benefits for routine cytology screenings are covered in full.

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

8. Mental Health Visits. We will provide coverage for up to 20 mental health visits in a Calendar Year for evaluation and short-term treatment, for conditions that can be expected to result in significant improvement within a relatively short period of time based on our clinical guidelines. Up to one hour of mental health treatment is allowed for each mental health visit.

   Services provided in a Professional Provider’s office pursuant to Section Nine, paragraph 16 and in the outpatient department of a Facility pursuant to this Section are subject to the visit limit above.

   In-Network Benefits and Out-of-Network Benefits for mental health services will both be counted toward this 20-visit maximum.

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

   Out-of-Network. Out-of-Network Benefits are covered at 50% of the Allowable Expense, after Deductible.
9. **Chemical Dependency.** We will provide coverage for outpatient visits in a Facility described below for the diagnosis and treatment of chemical dependence. Each individual visit must consist of at least one of the following: individual or group chemical dependence counseling; activity therapy; and diagnostic evaluations by a Professional Provider to determine the nature and extent of your illness or disability. We will not provide coverage for visits that consist primarily of participation in programs of a social, recreational, or companionship nature.

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

In-Network Benefits and Out-of-Network Benefits will both be counted toward this 60-visit maximum.

- **In-Network.** In-Network Benefits are subject to a $20 Copayment.
- **Out-of-Network.** Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

10. **Covered Therapies.** We will provide coverage for up to an aggregate of 45 visits per Member per Calendar Year for related rehabilitative physical therapy and physical, occupational, respiratory and speech therapy, when services are rendered by a licensed physical therapist, occupational therapist or speech language pathologist or audiologist and when we determine, in our sole judgment, that your condition is subject to significant clinical improvement through relatively short-term therapy.

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

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

- **In-Network.** In-Network Benefits are subject to a $20 Copayment.
- **Out-of-Network.** Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

11. **Cardiac Rehabilitation.** We will provide coverage for Medically Necessary cardiac rehabilitation programs on referral by a Professional Provider.

- **In-Network.** In-Network Benefits are subject to a $20 Copayment.
- **Out-of-Network.** Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

12. **Infertility Treatment Services.** We will provide coverage for Medically Necessary outpatient Facility care in connection with infertility treatment services provided by a Professional Provider pursuant to Section Nine, paragraph 19.

You are responsible for any applicable Deductible, Copayment or Coinsurance provisions under this section for similar services. For example, any Deductible, Copayment or Coinsurance that applies to Care in Connection with Surgery under Paragraph 1 will also apply to surgical services under this paragraph; and any Deductible, Copayment or Coinsurance for Diagnostic Procedures covered under Paragraph 3 will also apply to diagnostic procedures covered under this paragraph.

SECTION SEVEN - HOME CARE

1. **Type of Home Care Provider.** We will provide coverage for home care visits given by a certified home health agency or a licensed home care services agency if your In-Network Provider and our Medical Director determine that the visits are Medically Necessary.

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

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

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

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

C. The home care is related to an illness or injury for which you were hospitalized or for which you would have been hospitalized or confined in a Skilled Nursing Facility. This home care must be Medically Necessary at a skilled or acute level of care.
You will not be entitled to coverage of any home care after the date we determine, in our sole judgment, that you no longer need such services.

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

   A. Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse;
   B. Part-time or intermittent home health aide services which consist of primarily rendering direct care to you;
   C. Physical, occupational or speech therapy if provided by the home health care agency; and
   D. Medical supplies, drugs, and medications prescribed by your physician and laboratory services by or on behalf of the home health agency or home care services agency to the extent such items would have been covered under this Certificate if you were an inpatient in a Hospital or Skilled Nursing Facility.

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

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

4. **Payments for Home Care.**

   - **In-Network.** In-Network Benefits are covered in full.
   - **Out-of-Network.** Out-of-Network Benefits are covered at 75% of the Allowable Expense, after a $50 per Member per Calendar Year 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 we will provide coverage only for hospice care provided by a hospice organization which has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the hospice organization must have an operating certificate issued under criteria similar to those used in New York by a state agency in the state where the hospice care is provided, or it must be approved by Medicare.

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

   A. Bed patient care provided by the hospice organization either in a designated hospice unit or in a regular hospital bed;
   B. Day care services provided by the hospice organization;
   C. Home care and outpatient services which are provided and billed through the hospice. The services may include at least the following:
      1. intermittent nursing care by an R.N., L.P.N. or home health aide;
      2. physical therapy;
      3. speech therapy;
      4. occupational therapy;
      5. respiratory therapy;
      6. social services;
      7. nutritional services;
      8. laboratory examinations, X-rays, chemotherapy and radiation therapy when required for control of symptoms;
      9. medical supplies;
     10. drugs and medications that require a prescription by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary. We will not provide coverage when the drug or medication is of an experimental nature (see Section Eighteen, paragraph 32 for your right to an external appeal of our determination that a drug is experimental);
     11. durable medical equipment; and
     12. bereavement services provided to your family during illness, and until one year after death.
   D. Medical care provided by a physician.
4. **Number of Visits.** We will provide coverage for unlimited days of hospice care, beginning with the first day on which care is provided. Each day you receive care from or through the hospice counts as a day of hospice care. We will also provide coverage for up to five visits for bereavement counseling services to your family, either before or after your death.

5. **Payments for Hospice Care.**
   - **In-Network.** In-Network Benefits are covered in full.
   - **Out-of-Network.** Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

**SECTION NINE - PROFESSIONAL SERVICES**

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

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

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

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

2. **Covered Therapies.** We will provide coverage for up to an aggregate of 45 visits per Member per Calendar Year for related rehabilitative physical therapy and occupational, respiratory and speech therapy, when services are rendered by a licensed physical therapist, occupational therapist or speech language pathologist or audiologist and when we determine, in our sole judgment, that your condition is subject to significant clinical improvement through relatively short-term therapy.

   Services provided in the outpatient department of a Facility pursuant to Section Six, paragraph 10 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 this 45-visit maximum.

   - **In-Network.** In-Network Benefits are subject to a $20 Copayment.
   - **Out-of-Network.** Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

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. We will not provide coverage for the administration of anesthesia for a procedure not covered by this Certificate.

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

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

   A. We will provide benefits when:

   - (1) you seek the second surgical opinion after your surgeon determines your need for surgery; and
   - (2) the second surgical opinion is rendered by a physician
     a. who is a board certified specialist; and
     b. who, by reason of his or her specialty, is an appropriate physician to consider the proposed surgical procedure; and
   - (3) the second surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under this Certificate if such surgery was performed; and
   - (4) you are examined in person by the physician rendering the second surgical opinion; and
(5) the specialist who renders the opinion does not also perform the surgery.

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

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

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

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

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

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

6. Maternity Care. We will provide coverage for:

A. Normal Pregnancy. Maternity care includes the first visit upon which a positive pregnancy test is determined. It also includes all subsequent prenatal and postpartum care. These benefits include the services of a licensed midwife, under qualified medical direction, affiliated or practicing in conjunction with a Facility licensed under the New York Public Health Law.

In-Network. In-Network Benefits are covered in full after the initial prenatal visit which is subject to a $20 Copayment.

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

B. Complications of Pregnancy and Termination. We will provide coverage for complications of pregnancy and elective termination of pregnancy by abortion or miscarriage, including non-elective caesarean sections.

In-Network. In-Network Benefits are covered in full.

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

C. Anesthesia. We will provide coverage for delivery anesthesia.

In-Network. In-Network Benefits are covered in full.

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

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

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

In-Network. In-Network Benefits are covered in full.

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. We will provide coverage for the following health prevention programs rendered in the Professional Provider’s office or by other providers designated by the Medical Director:
(1) Routine Physical Examinations. We will provide coverage for periodic adult routine physical examinations in accordance with a schedule based on national coverage determinations, but not to exceed one (1) examination per Member, per Calendar Year.

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

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

(2) Well Child Visits and Immunizations. We will provide coverage for well child visits in accordance with the schedule recommended by the American Academy of Pediatrics. We will also cover childhood immunizations recommended by the American Academy of Pediatrics, in accordance with the Academy’s recommended schedule.

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

**In-Network.** In-Network Benefits are covered in full.

**Out-of-Network.** Out-of-Network Benefits are covered in full.

B. Other Health Services.

(1) Laboratory and Pathology Services. We will provide coverage for diagnostic laboratory and pathology services.

**In-Network.** In-Network Benefits are covered in full.

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

(2) Vision Examinations. We will provide coverage for diagnostic vision examinations to determine disease or injury to the eye.

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

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

(3) Hearing Examinations. We will provide coverage for diagnostic hearing evaluations to determine disease or injury to the ear.

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

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

C. Diagnostic Office Visits. We will provide coverage for diagnostic office visits.

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

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

D. Office Surgery. We will provide coverage for surgical procedures performed in the Professional Provider’s office.

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

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

E. Office Consultations. We will provide coverage for consultations billed by a physician. A consultation is professional advice given by a physician to your attending physician upon request of your attending physician.

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

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

9. Diagnostic Imaging Examinations and Diagnostic Radioactive Isotope Procedures. Subject to the provisions below, we will provide coverage for the professional component of x-ray examinations; radioactive isotope; ultrasound; CAT scan; and magnetic resonance imaging (“MRI”) procedures rendered and billed by a Professional Provider.
We will provide coverage for a CAT scan (computerized axial tomograph) or for any other radiation imagery procedure if it is performed by a Professional Provider in a Facility and the installation of the equipment required for the CAT scan or other procedure has been approved by law. If the CAT scan or other procedure is performed in New York State, the installation of the equipment must have been approved under the New York State Public Health Law. If it is performed outside New York State, the installation of the equipment must have the approval of a comparable state authority. If the CAT scan or other procedure is performed in a Professional Provider’s office, we will provide the CAT scan or other procedure only if the New York State 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 $20 Copayment.

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

10. Radiation Therapy and Chemotherapy. We will provide coverage for radiation therapy and chemotherapy.

In-Network. In-Network Benefits are covered in full.

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

11. Hemodialysis. We will provide coverage for hemodialysis treatments of an acute or chronic kidney ailment.

In-Network. In-Network Benefits are covered in full.

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

12. Mammography Screenings. We will provide coverage for mammography screenings for occult breast cancer. The screenings may be provided in a Professional Provider’s office under this Section or in the outpatient department of a Facility pursuant to Section Six, paragraph 6. Our coverage for routine mammography screenings under this Section and Section Six, paragraph 6 are subject to the following aggregate limitations:

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

B. Women 35 Through 39 Years of Age. We will provide coverage for one baseline mammogram for women 35 through 39 years of age.

C. Women 40 Years of Age and Older. We will provide coverage for one mammogram in each Calendar Year for women 40 years of age and older.

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

In-Network. In-Network Benefits are covered in full.

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

13. Gynecological Services. We will provide coverage for gynecology visits, including coverage for one screening for cervical cancer and its precursor states each Calendar Year for women 18 years of age and older. The screening may be provided in the outpatient department of a Facility pursuant to Section Six, paragraph 7 or in a Professional Provider’s office pursuant to this Section. Our coverage under this Section and Section Six are subject to the visit limit above. 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 cervical cytology screenings are covered in full. In-Network Benefits for other gynecology visits are subject to a $20 Copayment.

Out-of-Network. Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.
14. **Screenings for Prostate Cancer.** We will provide coverage for diagnostic screenings for prostate cancer when prescribed by a health care practitioner legally authorized to prescribe under Title 8 of the New York Education Law. Our coverage for prostate screenings shall be subject to the following limitations:

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

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

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

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

   - **In-Network.** In-Network Benefits are subject to a $20 Copayment.
   - **Out-of-Network.** Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

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

   - **In-Network.** In-Network Benefits for allergy testing are subject to a $20 Copayment. Allergy treatments are covered in full.
   - **Out-of-Network.** Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

16. **Mental Health Visits.** We will provide coverage for up to an aggregate of 20 mental health visits in a Calendar Year for evaluation and short-term treatment for conditions that can be expected to result in significant improvement within a relatively short period of time, or for the medical management of mental illness. Up to one hour of mental health treatment is allowed for each mental health visit.

   Services provided in the outpatient department of a Facility pursuant to Section Six, paragraph 8 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 this 20-visit maximum.

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

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

   A. rendered by a provider licensed to provide such services; and
   B. determined by us, in our sole judgment, to be Medically Necessary.

   - **In-Network.** In-Network Benefits are subject to a $20 Copayment.
   - **Out-of-Network.** Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

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

   A. The physician who is called in is a specialist in your illness or disease;
   B. The consultations take place while you are a registered bed patient in a Facility;
   C. The consultation is not required by the rules or regulations of the Facility;
   D. The consulting physician does not thereafter render care or treatment to you;
   E. The consulting physician enters a written report in your Facility records;
   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 in full.
   - **Out-of-Network.** Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.
19. **Infertility Treatment Services.** We will provide coverage for Medically Necessary services for the diagnosis and treatment of infertility subject to the following conditions:

A. **Infertility Defined.** For purposes of this paragraph, infertility has the meaning set forth in the regulations of the New York State Insurance Department. In general, infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse.

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

C. **Coverage Only Provided for Appropriate Candidates.** Coverage under this paragraph will only be provided to "Appropriate Candidates" within the age group described in Subparagraph B. An Appropriate Candidate is an individual determined to be an Appropriate Candidate by the treating physician, in accordance with the standards and guidelines established and adopted by the New York State Insurance Department by regulation.

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

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

2. Services in relation to diagnostic tests and procedures necessary:
   
   a. To determine infertility; or
   
   b. In connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered by this paragraph are:

   - Hysterosalpingogram;
   - Hysteroscopy;
   - Endometrial biopsy;
   - Laparoscopy;
   - Sono-hysterogram;
   - Post-coital tests;
   - Testis biopsy;
   - Semen analysis;
   - Blood tests;
   - Ultrasound; and
   - Other Medically Necessary diagnostic tests and procedures, unless excluded by law.

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

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

G. **Excluded Services.** We will not pay benefits for any services related to or in connection with:

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

H. **Experimental Procedures Not Covered.** This paragraph does not cover services or procedures that we, in our sole judgment, determine to experimental, according to standards and guidelines that are no less favorable than those established and adopted by the American Society for Reproductive Medicine. You may appeal our determination that a service or procedure is experimental to an external appeal agent as described in Section Eighteen, paragraph 32.
I. Deductibles, Copayments and Coinsurance. The benefits of this paragraph are subject to any applicable Deductible, Copayment or Coinsurance provisions under this section for similar services. For example, any Deductible, Copayment or Coinsurance for Surgical Care under Paragraph 1 will also apply to surgical services under this paragraph; any Deductible, Copayment or Coinsurance for Laboratory and Pathology Services under Paragraph 8 B. (1) will also apply to laboratory and pathology services under this paragraph; and any Deductible, Copayment or Coinsurance for x-ray and imaging procedures under Paragraph 9 will also apply to x-ray and imaging procedures under this paragraph.

20. Bone Density Testing. We will cover bone mineral density measurements and tests for the detection of osteoporosis. We will apply our standards and guidelines that are consistent with the criteria of the federal Medicare program or the National Institutes of Health ("NIH") to determine appropriate coverage for 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 $20 Copayment.

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

SECTION TEN - ADDITIONAL BENEFITS

1. Treatment of Diabetes. We will provide coverage for the following equipment and supplies for the treatment of diabetes which we determine, in our sole judgment, to be Medically Necessary and when prescribed or recommended by your Professional Provider or other In-Network medical personnel legally authorized to prescribe under Title 8 of the New York State Education Law ("Authorized Medical Personnel"):• insulin and oral agents for controlling blood sugar (limited to a 30-day supply);
• blood glucose monitors;
• blood glucose monitors for the visually impaired;
• data management systems;
• test strips for glucose monitors, visual reading and urine testing;
• injection aids;
• cartridges for the visually impaired;
• insulin pumps and appurtenances thereto;
• insulin infusion devices; and
• additional Medically Necessary equipment and supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

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

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

We will pay for diabetes self-management education and diet information provided by your Professional Provider or Authorized Medical Personnel, or their staff, in connection with Medically Necessary visits upon the diagnosis of diabetes, a significant change in your symptoms, the onset of a condition necessitating changes in self-management or where re-education or refresher education is Medically Necessary, as determined by us. When such education is provided as part of the same office visit or diagnosis or treatment of diabetes, payment for the office visit shall include payment for the education. We will also pay for home visits, when Medically Necessary.
Education is also covered when provided by the following 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 for diabetic supplies and insulin are subject to a $20 Copayment for each 30 day supply. In-Network Benefits for diabetic education are subject to a $20 Copayment. In-Network Benefits for diabetic durable medical equipment are subject to a $20 Copayment.

**Out-of-Network.** Out-of-Network Benefits for diabetic supplies and insulin, diabetic education and diabetic durable medical equipment are covered at 70% of the Allowable Expense, after Deductible.

2. **Ambulance Service.** We will provide coverage for Medically Necessary ground or air ambulance service provided by a Hospital, professional, or licensed ambulance service for a life-threatening or urgent condition. The ambulance must transport you to the nearest Facility for an inpatient admission or emergency outpatient care. If the nearest Facility cannot treat your disability or condition, we will provide coverage for ambulance service to the nearest Facility that can render the treatment you need. Medically Necessary transportation between Facilities is covered.

We will not pay for transportation by air ambulance unless you receive approval from our Medical Director before you receive transportation.

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

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

3. **Prehospital Emergency Services and Transportation.** We will provide coverage for services to evaluate and treat an “emergency condition” as that term is defined in the Emergency Care Section of this Certificate when such services are provided by an ambulance service certified under the Public Health Law. We will also provide coverage for land ambulance transportation to a Hospital by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

   A. placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
   B. serious impairment to such person’s bodily functions;
   C. serious dysfunction of any bodily organ or part of such person; or
   D. serious disfigurement of such person.

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

**Out-of-Network.** Out-of-Network Benefits are subject to a $20 Copayment.

4. **Individual Case Management.**

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

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

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

At the expiration of such 60-day period, you may apply in writing for a continuation of the alternative benefits and services being provided outside the terms of this Certificate. Upon such application for renewal, we will review the patient’s condition and may in our sole judgment agree to a renewal of such alternative benefits and services. Renewals must be in writing and our determination will be final.
The alternative benefits you receive will be in lieu of the benefits we would normally provide to you under this Certificate ("the contractual benefits") for the treatment of your condition. As a result, we may require you to agree to waive certain contractual benefits in order to receive the alternative benefits agreed upon. You may return to utilization of contractual benefits at any time upon prior written notice to us. However, the contractual benefits remaining available to you will be reduced in a manner that appropriately reflects the alternative benefits you used.

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

Corporate Managed Care
165 Court Street
Rochester, NY 14647

Or, you may contact our Member Services Department at the phone number located on your identification card.

SECTION ELEVEN - EMERGENCY CARE

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

1. Emergency Conditions. An Emergency Condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

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.

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

2. Eligibility for Benefits. We will provide coverage for care at the emergency room of an In-Network Provider or Out-of-Network Provider if your illness or condition is considered an Emergency Condition. We will provide coverage for medical visits of Professional Providers that are not Facility employees or interns in an emergency room to treat an Emergency Condition.

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

3. Payment for Emergency Care in a Hospital Emergency Room.

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

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

This Copayment will be waived if you admitted to the Hospital as an inpatient within 24 hours of the emergency room visit.

4. Payment for Emergency Care in a Freestanding Urgent Care Center. We will provide coverage for care at a freestanding urgent care center if your illness or condition is considered an Emergency Condition.

   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.

5. Payment for a Professional Provider’s Hospital Emergency Room Visit. We will provide coverage for visits of Professional Providers if your illness or condition is considered an Emergency Condition. We will not provide coverage for medical visits by Facility employees or interns, even if they are Professional Providers.

   In-Network. In-Network Benefits are covered in full.

SECTION TWELVE - HUMAN ORGAN AND BONE MARROW TRANSPLANTS

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

1. **Prior Approval Required.** All organ transplants must be pre-approved by us. See Section Three for our pre-approval procedures. You or your Professional Provider must call us within one week prior to admission to seek approval. In the event of the availability of an organ for transplantation resulting in the necessity for an immediate admission for implantation, you must call us within twenty-four (24) hours after your admission or as soon thereafter as reasonably possible. If you fail to seek our prior approval for an organ transplant, we will provide coverage for an amount of $500 less than we would otherwise cover for the care, or we will provide coverage for only 50% of the amount we would otherwise have covered for the care, whichever results in a greater benefit to you. You must pay the remaining charges. We will provide coverage for the amount specified above only if we determine the care was Medically Necessary even though you did not seek our prior approval. If we determine, in our sole judgment, that the services were not Medically Necessary, you will be responsible for paying the entire charge for the service.

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

3. **No Coverage of Experimental or Investigational Organ Transplants.** We will not provide coverage for any benefits for an organ transplant we determine in our sole judgment to be experimental or investigational. We maintain and revise from time to time a list of organ transplant procedures which we determine not to be experimental or investigational and therefore are covered under this Certificate. You may contact us if you have a question concerning whether a particular transplant procedure is covered. See Section Eighteen, paragraph 32 for your right to an external appeal of our determination that an organ transplant is experimental or investigational.

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

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

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

SECTION THIRTEEN - EXCLUSIONS

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

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

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

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

4. **Contraceptive Drugs and Devices.** We will not provide coverage for any service or care related to contraceptive drugs or devices, including, but not limited to, family planning services, implantable drugs, intra-uterine devices, and diaphragms.
5. **Custodial Care.** We will not provide coverage for any service or care related to the treatment of an illness, accident or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred.

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

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

8. **Medical Supplies.** We will not provide coverage for any service or care related to the educational treatment of behavioral disorders together with services for remedial education, including evaluation or treatment of learning disabilities, minimal brain dysfunction, development and learning disorders, behavioral training, and cognitive rehabilitation. This exclusion applies to services, treatment, or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language, to instruct a Member whose ability to speak has been lost or impaired to function without that ability, is not covered.

9. **Developmental Delay.** We will not provide coverage for any service or care related to the educational treatment of behavioral disorders together with services for remedial education, including evaluation or treatment of learning disabilities, minimal brain dysfunction, development and learning disorders, behavioral training, and cognitive rehabilitation. This exclusion applies to services, treatment, or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language, to instruct a Member whose ability to speak has been lost or impaired to function without that ability, is not covered.

10. **Durable Medical Equipment; Prosthetic Devices; Medical Supplies.** We will not provide coverage for any service or care related to:

A. the rental, purchase, repair, or maintenance of durable medical equipment (for example, respirators, canes, crutches, walkers, wheelchairs, trusses, apnea monitors, oxygen-related equipment, special hospital-type beds, or home dialysis units);
B. prosthetic devices (except as set forth in Section Five, paragraph 5), artificial aids, corrective appliances, or their replacements (for example, braces and artificial arms, legs, and eyes);

C. medical supplies (for example, ostomy supplies, catheters, dressings, and elastic stockings);

D. disposable supplies (for example, diapers, chux, sponges, syringes, incontinence pads, reagent strips, and bandages prescribed for one-time use outside of a provider site); except that this exclusion does not apply to diabetic supplies covered under Section Ten;

E. wigs, hair prosthetics, or hair implants;

F. orthotics, including, but not limited to, custom-made shoes and arch supports; and

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

12. Reversal of elective sterilization. We will not provide coverage for any service or care related to the reversal of elective sterilization, unless Medically Necessary. When sterilization is Medically Necessary, we will provide benefits only for sterilization of the covered person whose medical condition requires it.

13. Experimental and Investigational Services. Unless otherwise required by law, we will not provide coverage for any service or care that consists of a treatment, procedure, drug, biological product, or medical device (collectively, “Service”); an inpatient stay in connection with a Service; or treatment of a complication related to a Service; if, in our sole judgment, the Service is experimental or investigational. See Section Eighteen, paragraph 32 for your right to an external appeal of our determination that a Service is experimental or investigational.

"Experimental or investigational" means that we determine the Service is:

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

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

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

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

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

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

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

C. Published, peer-reviewed, medical literature must provide demonstrated evidence that, over time, the Service leads to improvement in health outcomes, i.e., the beneficial effects of the Service outweigh any harmful effects.
D. Published, peer-reviewed, medical literature must provide proof that the Service is at least as effective in improving health outcomes as established services or technology, or is usable in appropriate clinical contexts in which an established service or technology is not employable.

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

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

14. **Free Care.** We will not provide coverage for any service or care that is furnished to you without charge, or that would have been furnished to you without charge if you were not covered under this Certificate. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your spouse, brother, sister, mother, father, son or daughter; or the spouse of any of them; we will presume that the service or care would have been furnished without charge. You must prove to us that a service or care would not have been furnished without charge.

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

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

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

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

   (1) the Subscriber is in “current employment status” (working actively and not retired) with the group contract holder; and

   (2) the Subscriber’s employer maintains or participates in an employer group health plan that is required by law to have this Certificate pay its benefits before Medicare.

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

   (1) the Subscriber is in “current employment status” (working actively and not retired) with the group contract holder; and

   (2) the Subscriber’s employer maintains or participates in a large group health plan, as defined by law, that is required by law to have this Certificate pay its benefits before Medicare pays.

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

17. **Hypnosis/Biofeedback.** We will not provide coverage for hypnosis or biofeedback.

18. **Inpatient Rehabilitation for Chemical Dependence or Abuse.** We will not provide coverage for inpatient rehabilitation for chemical dependence or abuse.

19. **Military Service-Connected Conditions.** We will not provide coverage for any service or care related to any military service-connected disability or condition, if the Veterans Administration (VA) has the responsibility to provide the service or care.
20. **No-Fault Automobile Insurance.** We will not provide coverage for any service or care for which benefits are available under mandatory no-fault automobile insurance, until you have used up all of the benefits of the mandatory no-fault policy. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy. We will provide benefits for services covered under this Certificate when you have exceeded the maximum benefits of the no-fault policy. Should you be denied benefits under the no-fault policy because it has a Deductible, we will provide coverage for the services covered under this Certificate, up to the amount of the Deductible. We will not provide benefits even if you bring a lawsuit against the person who caused your injury and even if you receive money from that lawsuit and you have repaid the medical expenses you received payment for under the mandatory automobile no-fault coverage.

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

22. **Nutritional Therapy.** We will not provide coverage for any service or care related to nutritional therapy, unless we determine that it is Medically Necessary or that it qualifies as diabetes self management education. We will not provide coverage for commercial weight loss programs or other programs with dietary supplements.

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

24. **Prescription Drugs.** We will not provide coverage for service or care related to prescription drugs, over-the-counter (nonprescription) drugs, or immunizations, except for prescription drugs, and/or immunizations that are administered to you in the course of a covered outpatient or inpatient treatment in a Facility or Professional Provider’s office, or through home health care benefits, except for insulin and oral agents for controlling blood sugar.

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

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

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

28. **Routine Care of the Feet.** We will not provide coverage for services related to routine care of the feet, including but not limited to corns, callouses, flat feet, fallen arches, weak feet, chronic foot strain, toenails, or symptomatic complaints of the feet.

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

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

31. **Services Starting Before Coverage Begins.** If you are receiving care on the day your coverage under this Certificate begins, we will not provide coverage for any service or care you receive:
   A. prior to the first day of your coverage under this Certificate; or
   B. on or after the first day of your coverage under this Certificate, if that service or care is covered under any other health benefits contract, program, or plan.

You must notify us, within 48 hours after your coverage begins, that you are receiving care.

32. **Smoking Cessation Programs.** We will not provide coverage for smoking cessation programs.
33. **Special Charges.** We will not provide coverage for charges billed to you for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, or completion of claims forms. This exclusion applies to any late charges or extra day charges that you incur upon discharge from a Facility, because you did not leave the Facility before the Facility’s discharge time.

34. **Social Counseling and Therapy.** We will not provide coverage for any service or care related to family, marital, religious, sex, or other social counseling or therapy, except as otherwise provided under this Certificate.

35. **Transsexual Surgery and Related Services.** We will not provide coverage for any service or care related to transsexual surgery, including, but not limited to, hormone therapies; procedures, treatments, or related services designed to alter the physical characteristics of your biologically determined gender to those of another gender; even if you have been diagnosed as having gender role or psychosexual orientation problems.

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

37. **Vision and Hearing Examinations, Therapies, and Supplies.** We will not provide coverage for any service or care related to:
   
   A. routine eye or hearing examinations for the purpose of prescribing, fitting, servicing, or changing eyeglasses, contact lenses, or hearing aids; except for the initial prescription for contact lenses or lenses and frames after cataract surgery;
   
   B. eyeglasses, lenses, frames, contact lenses, or hearing aids except for the initial prescription for contact lenses or lenses and frames after cataract surgery; and
   
   C. vision or hearing therapy, vision training, or orthoptics.

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

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

**SECTION FOURTEEN - WAITING PERIODS**

1. **Pre-existing Conditions.** We will not provide coverage for any services related to a Pre-existing Condition until you have been continuously covered under this Certificate or other creditable coverage for at least 11 consecutive months. This provision will not apply if your group has more than 300 members.

   A Pre-existing Condition is any physical or mental condition; disease; or ailment for which medical advice, diagnosis, care or treatment was actually recommended or received by a licensed health care provider within the six (6) month period preceding your Enrollment Date. The Enrollment Date is the first of the following:
   
   A. Your Effective Date under this Certificate; or
   
   B. The first day of the waiting period that your group requires you to meet before you are eligible for coverage.

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

   Creditable coverage includes coverage provided through: health insurance; self-insured group health benefit plans; Medicaid; Medicare; government-sponsored health benefit programs, such as CHAMPUS, Peace Corps, or Indian Health Service; Federal Employees Health Benefits Program; a state health benefits risk pool; or any health insurance plan sponsored by a state, county, or other political subdivision of a state.
You have the right to obtain a certificate from the employer, insurer, HMO or governmental health benefit plan that provided your prior creditable coverage. The certificate will enable you to demonstrate the prior creditable coverage that will be counted toward fulfillment of the pre-existing condition waiting period under this Certificate. Contact us if you need help obtaining a certificate for your prior creditable coverage.

3. Exceptions. Pre-existing Condition waiting periods will not be imposed with respect to: (a) pregnancy; (b) any condition afflicting a newborn who is covered under creditable coverage on the 30th day following birth, provided that there has not been a continuous lapse of more than 63 days between the end of the creditable coverage and the child’s enrollment date for coverage under this Certificate; (c) any condition afflicting an adopted child under age eighteen (18) who is covered under creditable coverage on the 30th day following adoption or placement for adoption, provided that there has not been a continuous lapse of more than 63 days between the end of the creditable coverage and the child’s enrollment date for coverage under this Certificate; or (d) genetic information, including gene products; inherited characteristics that may derive from the individual or family member, including information regarding carrier status and information derived from lab tests that identify mutations in specific genes or chromosomes; physical medical examinations; family histories; and direct analysis of genes or chromosomes. However, if, within the six (6) month period prior to your Enrollment Date, you have been diagnosed with and have received medical advice or treatment for the condition indicated by the genetic information, the Pre-existing Condition waiting period will apply.

SECTION 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 or policies ("plans") providing similar benefits both issued through or to groups. When that is the case and you receive an item of service that would be covered by both plans, we will coordinate benefit payments with any payment made under the other plan. One company will pay its full benefit as the primary plan. The other company will pay secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   We count as actually paid by the primary plan any items of expense that would have been paid if you had made the proper and timely claim. We will request information from that plan so we can process your claims. If the primary plan does not respond within 30 days, we will assume its benefits are the same as ours. If the primary plan sends the information after 30 days, we will adjust our payment, if necessary.

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

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

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

6. **Our Right to Recover Overpayment.** In some cases we may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other plan. You must sign any document which we deem necessary to help us recover any overpayment.

**SECTION SIXTEEN - TERMINATION OF YOUR COVERAGE**

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

1. **Termination of the Group Contract.** This Certificate is provided under the terms of the Group Contract between us and the group contract holder. The Group Contract is effective for one year and will automatically be renewed each year unless it is terminated as set forth below.

   A. The group contract holder terminates the Group Contract pursuant to its terms. In this case, your coverage will terminate on the date the group contract holder terminates;

   B. We do not receive premium payment from the group contract holder as of the date the premium was due. In this case, your coverage will end on the date to which the premium has been paid;

   C. The group contract holder has committed fraud or made an intentional misrepresentation of material fact under the terms of the Group Contract. In this case, your coverage will terminate thirty (30) days from the date we provide notice to you;
D. The group contract holder no longer qualifies as a group. We have certain administrative rules that describe our requirements for group contract holders. Our rules are consistent with New York State law and regulations governing health insurance. If you have a question about the rules that apply to your group contract holder, you may contact us and we will explain them to you.

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

E. The group contract holder fails to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under Section 4235 of the Insurance Law. In this case, your coverage will terminate thirty (30) days from the date we provide notice to you;

F. The group contract holder no longer has any enrollee living, residing or working in New York State. Your coverage will terminate thirty (30) days from the date we provide notice to you;

G. Any reason approved by the New York State Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act. In this case, your coverage will terminate thirty (30) days from the date we provide notice to you. A copy of the reason for the termination of your coverage will be provided to you upon request;

H. If we terminate the entire class of contracts to which this Certificate belongs. In this case, your coverage will terminate ninety (90) days from the date we provide notice to you;

I. If we withdraw from the applicable market through which you obtained coverage under this Certificate, and we cease offering any products in that market. In this case, your coverage will terminate six (6) months from the date we provide notice to you.

2. **Termination of Your Coverage Under this Certificate.** In the following instances, the Group Contract will continue in force, but your coverage under this Certificate will be terminated:

A. You choose to terminate your coverage. You must give the group contract holder thirty (30) days' written notice. Your coverage will terminate on the date to which your premium is paid;

B. You are no longer a member of the group. Your coverage will terminate on the date to which your premium is paid if you are no longer a member of the group;

C. You committed fraud in applying for coverage or in filing a claim under this Certificate. Your coverage will terminate thirty (30) days from the date we provide notice to you;

D. Any reason approved by the Superintendent of Insurance. In this case, your coverage will terminate thirty (30) days from the date we provide notice to you. A copy of the reason for the termination of your coverage will be provided to you upon request;

E. On your death or the death of the Subscriber. Your coverage under this Certificate will automatically terminate on the date after your death or the death of the Subscriber.

F. Termination of the Subscriber’s marriage. If the Subscriber becomes divorced, or the Subscriber’s marriage is annulled, coverage of the Subscriber’s spouse under this Certificate will automatically terminate on the date of the divorce or annulment; or

G. Termination of coverage of a child. Coverage of a Subscriber’s child under this Certificate will automatically terminate on the date the child no longer qualifies as a dependent under Section Two of this Certificate.

3. **Continued Benefits after Termination for Total Disability.** When your coverage under this Certificate ends, benefits stop. However, if you are, in our sole judgment, totally disabled on the date the group contract terminates, or on the date your coverage under this Certificate terminates, and you have received services or care for the illness, condition, or injury that caused your total disability while you were covered under this Certificate, continued benefits may be available to you as follows:

A. **When you may continue benefits.** When you are totally disabled, you may continue benefits for covered services to treat the total disability, if one of the following applies:

   (1) Termination of employment, eligibility, or contract. When your coverage under this Certificate ends because:

      - you are no longer actively employed;
      - you are no longer eligible for coverage under this Certificate;
      - the group contract terminates;
we will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within 31 days from the date your coverage ends. The Hospital stay and/or surgery must be for treatment of the injury, sickness, or pregnancy causing the total disability.

(2) Termination of active employment. If your coverage ends because you are no longer actively employed, we will provide benefits during a period of total disability for up to 12 months from the date your coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability; unless coverage is provided for services in connection with the total disability under another group health plan.

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

(1) you have used all the benefits available;
(2) we determine that you are no longer totally disabled;
(3) you reach the lifetime maximum amount payable by us; or
(4) benefits are continued under Subparagraph A.(2) above, and you reach the end of the 12-month period from the date your coverage under this Certificate ends.

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

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

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

A. You are not entitled to Medicare; and you are not covered under or eligible for other group coverage that does not exclude or limit coverage for pre-existing conditions;
B. You must request continued coverage within 60 days after the later of: the date of termination; or the date you are given notice of continuation by the group. If you wish continuation under Subparagraph D.(4) below, you must notify the group within 60 days after a determination that you were disabled under the Social Security Act at the time of termination of employment or membership or within the first sixty days of continuation coverage;
C. You must pay the premium (not more frequently than monthly) when due. The first payment is due within 60 days after the later of the date coverage would otherwise terminate or the date you are given notice of continuation by the group. The premium cannot exceed 102% of the group’s premium rate;
D. Coverage will terminate at the earliest of the following:

(1) The date 18 months after your coverage would have terminated because of termination of employment or membership;
(2) The date to which premiums are paid if you fail to make a timely payment;
(3) If you are an eligible dependent, the date 36 months after coverage would have otherwise terminated due to: death of the employee or member; divorce or legal separation, the employee or member’s eligibility for Medicare; failure to qualify under the definition of “children;”
(4) The date 29 months after coverage would have otherwise terminated because of termination of employment or membership if the employee or member is determined to have been disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first sixty days of continuation coverage. However, if the employee or member is no longer disabled, coverage will terminate at the later of the date in Subparagraph D.(1) above; or the month that begins more than 31 days after determination that the employee or member is no longer disabled; or
5. **Supplementary Suspension, Continuation and Conversion Rights.** If you, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, and you enter active duty but the group contract holder does not voluntarily maintain your coverage, your coverage shall be suspended unless you elect in writing to the group contract holder, within 60 days of being ordered to active duty, to continue coverage under this Certificate for yourself and eligible dependents. Continued coverage shall not be subject to evidence of insurability. You must pay the required group rate premium in advance to the group contract holder, but not more frequently than once a month.

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

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

A. A condition that arose during the period of active duty and that has been determined by the secretary of veteran’s affairs to be a condition incurred in the line of duty; or

B. A waiting period imposed that had not been completed prior to the period of suspension. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed eleven months.

In the event that you are not reemployed or restored to participation in the group upon return to civilian status, you shall have the right within 31 days of the termination of active duty, or discharge from hospitalization incident to active duty which continues for a period of not more than one year, to submit a written request for continuation to the group, or a request for conversion directly to us, as described elsewhere in this Certificate. Such individual conversion policy shall be effective on the day after the end of the period of supplementary continuation.

If other than individual coverage applies and you elect supplementary continuation or if coverage is suspended, the supplementary conversion right shall be available to your spouse if divorce or annulment of the marriage occurs during the period of active duty, and if you die while on active duty, to your spouse and children covered under this Certificate, and to each child individually upon attaining the limiting age of coverage under this Certificate.

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

**SECTION SEVENTEEN - RIGHT TO NEW CONTRACT AFTER TERMINATION**

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

1. **Termination Of The Group Contract.** If the Group Contract between us and the group contract holder is terminated as set forth in Section Sixteen, paragraph 1, and the group contract holder has not replaced the coverage for the group with similar and continuous health care coverage, whether insured or self-insured, you are entitled to purchase a new contract as a direct payment Member.

2. **If You Are No Longer Covered in a Group.** If your coverage under this Certificate terminates under Section Sixteen, paragraph 2.B because you are no longer a member of a group, you are entitled to purchase a new contract as direct payment Member.

3. **On The Death of the Subscriber.** If your coverage under this Certificate terminates under Section Sixteen, paragraph 2.E because of the death of the Subscriber, you are entitled to purchase a new contract as a direct payment Member.

4. **Termination Of Your Marriage.** If your coverage under this Certificate terminates under Section Sixteen, paragraph 2.F because you become divorced from the Subscriber or your marriage is annulled, you are entitled to purchase a new contract as a direct payment Member.

5. **Termination of Coverage of a Child.** If your coverage under this Certificate terminates under Section Sixteen, paragraph 2.G because you no longer qualify as a child, you are entitled to purchase a new contract as a direct payment Member.
6. Termination of Your Temporary Continuation of Coverage. If your coverage under this Certificate terminates under Section Sixteen, paragraph 4 because you are no longer eligible for continuation of coverage, you are entitled to purchase a new contract as a direct payment Member.

7. When to Apply for the New Contract. If you are entitled to purchase a new contract, as described above, you must apply to us for the new contract within 45 days after termination of your coverage under this Certificate. You must also pay the first premium of the new contract within this same 45-day period.

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

A. We determine that similar coverage is available through the local Blue Cross and/or Blue Shield Plan operating in the area in which you are located; and

B. The time you were covered under this Certificate will count towards any applicable waiting periods under the available coverage.

8. The New Contract. The new contract will be our standard HMO contract issued upon conversion; or the new contract will be the type of coverage most commonly issued to group remitting agents.

SECTION EIGHTEEN - GENERAL PROVISIONS

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

2. Notice. Any notice that we give to you under this Certificate will be mailed to your address as it appears on our records or to the address of the group contract holder. If you have to give us any notice, it should be mailed to 165 Court Street, Rochester, NY 14647.

3. Your Medical Records. In order to provide your coverage under this Certificate, it may be necessary for us to obtain your medical records and information from Facilities or Professional Providers who treated you.

Our actions to provide that coverage include processing your claims, reviewing grievances or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you become covered under this Certificate, you automatically give us permission to obtain and use those records for those purposes.

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

4. Who Receives Payment Under This Certificate. Payments under this Certificate for service provided by an In-Network Provider will be made directly by us to the In-Network Provider. If you receive services from an Out-of-Network Provider, we reserve the right to pay either you or the Out-of-Network Provider.

5. Time to File Claims. Claims for services under this Certificate must be submitted to us for payment within twelve (12) months after you receive the services for which payment is being requested.

6. Time To Sue. No action at law or in equity may be maintained against us prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Certificate. You must start any lawsuit against us under this Certificate within twenty-four months from the date you received the service for which you want us to pay.

7. Venue for Legal Action. If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against us in a court anywhere else. You also consent to these courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order you to defend any action we bring against you.

8. Choice of Law. This Certificate shall be governed by the laws of the State of New York.

9. Recovery of Overpayments. On occasion a payment will be made when you are not covered, for a service that is not covered, or which is more than is proper. When this happens we will explain the problem to you and you must return the amount of the overpayment to us within 60 days after receiving notification from us.
10. **Right to Offset.** If we make a claim payment to you or on your behalf in error or you owe us any money, you must repay the amount you owed to us. If we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we owe you.

11. **Continuation of Benefit Limitations.** Some of the benefits under this Certificate are limited to a specific number of visits, and/or subject to deductible or annual maximums. You will not be entitled to any additional benefits if your coverage status should change during the Calendar Year or if you change from one Excellus Health Plan Certificate to another Excellus Health Plan Certificate of equal or like benefits. For example, if your coverage status changes from dependent to Subscriber, all benefits previously utilized when you were a dependent will be applied toward your new status as a Subscriber. Similarly, if you switch from one Excellus Health Plan certificate to another Excellus Health Plan certificate, all benefits utilized under your initial certificate will be counted toward the benefit limits under your new certificate.

12. **Eligibility for Benefits.** Our determination with respect to eligibility for benefits under this Certificate or the construction of any of the terms of this Certificate which may apply in any way to any claim you might make, or any rights you might have, under this Certificate shall be final and binding on you so long as our determination or construction is not arbitrary or capricious.

13. **Subrogation.** In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and we pay benefits as a result of that injury or illness, we will be subrogated and succeed to the right of recovery against the party responsible for your illness or injury to the extent of the benefits we have paid.

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

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

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

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

14. **Who May Change This Certificate.** The Certificate may not be modified; amended; or changed, except in writing, and signed by our Chief Operating Officer (COO) or a person designated by the COO. No employee; agent; or other person is authorized to interpret; amend; modify; or otherwise change the Certificate in a manner that expands or limits the scope of coverage; or the conditions of eligibility; enrollment; or participation, unless in writing and signed by the COO or person designated by the COO.

15. **Changes In This Certificate.** We may unilaterally change this Certificate upon the group’s renewal, if we give the group contract holder forty-four (44) days’ prior notice.

16. **Renewal Date.** The renewal date for the Certificate is January 1 of each year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by us or the group contract holder as permitted by the Certificate or by you upon 30 days prior written notice to the group contract holder.

17. **Agreements Between The Plan and In-Network Providers.** Any agreement between us and In-Network Providers may only be terminated by us or the In-Network Providers. This Certificate does not require any provider to accept a Member as a patient. We do not guarantee a Member’s admission to any In-Network Provider or any health benefits program.

18. **Material Accessibility.** We will give the group contract holder, and the group contract holder will give Members, identification cards, Certificates, Riders and other necessary materials.

19. **Refund.** We will give any refund of premiums, if due, to the group contract holder.
20. **Notice of Claim.** Claims for services under this Certificate must include all information designated by us as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, social security number, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information.

21. **Notice of Claim Determination.** We will provide an explanation of benefits to you when a claim is denied in whole or in part and as a result, you incur out of pocket expenses other than any applicable Deductibles, Coinsurance, or Copayments.

22. **Identification Cards.** Identification cards are issued by us for identification only. Possession of any identification card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits the Member’s premiums must be paid in full at the time that the services are sought to be received. Coverage under this Certificate may be terminated by us if the Member allows another person to wrongfully use the identification cards.

23. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards which describe in more detail when we will make or will not make payments under this Certificate. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether emergency care in the outpatient department of a Facility was necessary; or whether certain services are Skilled Care. Those standards will not be contrary to the descriptions in this Certificate. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Certificate.

24. **Furnishing Information and Audit.** The group contract holder and all persons covered under this Certificate will promptly furnish us with all information and records which we may require from time to time to perform our obligations under this Certificate. You must provide us with information over the telephone for reasons like the following: to allow us to determine the level of care you need; so that we may certify care authorized by your physician; or to make decisions regarding the Medical Necessity of your care. The group contract holder will, upon reasonable notice, make available to us, and we may audit and make copies of, any and all records relating to group enrollment at the group contract holder’s New York office.

25. **Enrollment; ERISA.** The group contract holder further will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages and social security numbers of all group members covered under this Certificate, and any other information required to confirm their eligibility for coverage. The group contract holder will provide us with the enrollment form including your name, address, age, and social security number and to advise us in writing when you are to be added to or subtracted from our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date the group’s contract with us. If the group contract holder fails to so advise us, the group contract holder will be responsible for the cost of any claims paid by us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 60 days.

The group contract holder may also have additional responsibilities as the “plan administrator” as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The "plan administrator" is the group contract holder, or a third party appointed by the group contract holder. Excellus Health Plan, Inc. is not the ERISA plan administrator.

26. **Reports and Records.** We are entitled to receive from any provider of services to Members, information reasonably necessary to administer this Certificate subject to all applicable confidentiality requirements as defined in the General Provisions section of this Certificate. By accepting coverage under this Certificate, the Member, for himself or herself, and for all covered dependents covered hereunder, authorizes each and every provider who renders services to a Member hereunder to:

A. disclose all facts pertaining to the care, treatment and physical condition of the Member to us or a medical, dental, or mental health professional that we may engage to assist it in reviewing a treatment or claim, or in connection with a complaint or quality of care review;

B. render reports pertaining to the care, treatment and physical condition of the Member to us, or a medical, dental, or mental health professional, that we may engage to assist us in reviewing a treatment or claim; and

C. permit copying of the Member’s records by us.
27. **Inability to Provide Service.** In the event that due to circumstances not within our reasonable control, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the In-Network Provider network, the rendition of medical or Facility benefits or other services provided under this Certificate is delayed or rendered impractical, we shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by us on the date such event occurs. We are required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

28. **Service Marks.** Excellus Health Plan, Inc. (“Excellus”), is an independent corporation organized under the Insurance Law of New York State. Excellus also operates under licenses with the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans, which licenses Excellus to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus does not act as an agent of the Blue Cross and Blue Shield Association. Excellus is solely responsible for the obligations created under this agreement.

29. **BlueCard - Calculation of Member Liability.** Like all Blue Cross and Blue Shield Licensees (hereinafter “Plans”), we participate in a program called the BlueCard Program. This program provides benefits when you are outside our Service Area. When you receive health care services outside our Service Area from a provider that participates with a Blue Cross and Blue Shield Plan, your claims may be processed through the BlueCard Program.

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

A. The provider’s billed charges; or

B. The negotiated price that the out-of-area Blue Cross and Blue Shield Plan passes on to us. This negotiated price may be:

   (1) The price the out-of-area Blue Cross and Blue Shield Plan paid its provider; or

   (2) An estimated price that includes expected settlements, withholds, other payment arrangements, or non-claims transactions with the provider that the out-of-area Blue Cross and Blue Shield Plan factored in; or

   (3) An average price that includes reductions to the bill that reflects the out-of-area Blue Cross and Blue Shield Plan’s average expected savings.

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

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

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

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

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

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

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

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

   Qualified personnel will review your grievance, or if it’s a clinical matter, a licensed, certified or registered health care professional will look into it.
B. **Notice of Determination.** The notice of determination of your grievance will include detailed reasons and, if a clinical matter is involved, the clinical rationale, and further appeal rights, if any. We will send notices to you or your representative and to your health care provider.

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

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

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

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

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

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

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

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

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

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

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

If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.
C. **Retrospective Reviews.** At our option, a nurse will review retrospectively the Medical Necessity of claims that are subject to Utilization Review. If the nurse determines that care you received was Medically Necessary, the nurse will authorize the benefits. If the nurse determines that Medical Necessity was lacking, the nurse will refer the case to a licensed physician.

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

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

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

E. **Internal Appeals of Adverse Determinations.**

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

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

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

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

For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request.
If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal. Our failure to render a determination of your internal appeal within 60 calendar days shall be deemed a reversal of the initial adverse determination.

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

32. External Appeal.

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

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

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

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

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

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

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

To request external appeal under this subparagraph, the final adverse determination must indicate that the requested service is not Medically Necessary.

Subparagraph G below provides information on requesting an external appeal.

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

In order to request an external appeal under this subparagraph, your attending physician must certify that you have a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one that, according to the current diagnosis of your attending physician, has a high probability of causing your death. A “disabling condition or disease” is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.
In addition, your attending physician must certify:
- that standard health services or procedures have been ineffective, or would be medically inappropriate in treating your life-threatening condition or disease; or, that no more beneficial standard treatment exists which is a covered service under this Certificate.

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

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

F. Effect of the External Appeal Agent's Decision; Coverage. The decision of the External Appeal Agent is binding on both parties. If the External Appeal Agent decides in our favor, we will not cover the requested service. If the external appeal agent decides in your favor, we will cover the service as follows:
- for services denied as not Medically Necessary, we will treat the service as Medically Necessary and provide coverage subject to all other conditions of this Certificate.
- for services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of this Certificate.
- for services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of this Certificate. We are not required to pay for drugs or devices that are the subject of the clinical trial.

We will not provide coverage for any service that is not a covered service under this Certificate. In addition, this section does not alter any Coinsurance, Copayment or Deductible responsibilities as otherwise provided for in this Certificate.

G. Requesting an External Appeal. If you meet the conditions described above, you may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your physician may file an appeal on your behalf. We will send a standard request form to you when we have made a final adverse determination at the first level of the internal appeal process. You or your physician may obtain additional standard request forms at any time from the State Insurance Department, the Department of Health, or by contacting us.
You must file your request for an external appeal with the State Insurance Department within 45 days of receiving a final adverse determination as a result of the first level appeal process, or within 45 days of receiving a letter from us waiving the internal review process. We do not have the authority to grant extensions of this deadline.

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

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

If you do not understand any part of the external appeal process or if you have questions regarding your right to external appeal, you may contact us, the State Insurance Department, or the Department of Health.
RIDER FOR EXTERNAL APPEALS INVOLVING RARE DISEASES
AND PRIOR APPROVAL OF HOME CARE SERVICES

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

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

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

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

   B. **Certifying Physician.** The physician must be a licensed, board-certified or board-eligible physician who specializes in the area of practice appropriate to treat your Rare Disease.

   C. **Conditions for External Appeals Involving Rare Disease Treatment.** In order to request an external appeal under this Rider, the following conditions must be met:

      (1) **Certification.** A physician, other than your treating physician, who meets the requirements in Subparagraph B above, must certify in writing that:

          (a) You have a Rare Disease as defined above.
          
          (b) That your Rare Disease is currently, or has been, subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or affects less than 200,000 United States residents per year.
          
          (c) Based on the physician’s credible experience, there is no standard treatment that is likely to be clinically more beneficial to you than the requested health service or procedure; the requested health service or procedure is likely to benefit you in the treatment of your Rare Disease; and that such benefit to you outweighs the risks of such health service or procedure.
(2) **Required Disclosure by the Certifying Physician.** The certifying physician must disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for external appeal of a denial of your Rare Disease treatment.

(3) **Institutional Review Board.** If the provision of the requested health service or procedure at a facility requires prior approval of an institutional review board, you or your designee must submit such approval as part of the external appeal application.

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

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

   A. **When we will make a Determination.** After receiving a request for approval of home care services following an inpatient admission, we will review the reasons for your planned home care services and determine if benefits are available. We will notify you and your Professional Provider of our decision by telephone and writing: within one business day of receipt of all necessary information; or, when the day subsequent to the request falls on a weekend or holiday, within 72 hours of receipt of all necessary information.

   B. **Requests prior to Discharge.** When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home care services, either on the basis of Medical Necessity or for failure to obtain prior authorization, while our decision on the request is pending.

   C. **Internal Appeals of Adverse Determinations.** We will handle the review of an appeal of an adverse determination of a home care prior approval request on an expedited basis. For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours after receipt of the appeal request. Our failure to render a determination of your expedited appeal within two business days of receipt of the information necessary to conduct the appeal shall be deemed a reversal of the initial adverse determination.

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

**EXCELLUS HEALTH PLAN, INC.**

doing business as

Excellus BlueCross BlueShield

165 Court Street

Rochester, NY 14647

By: [Signature]

Christopher C. Booth

President and Chief Executive Officer
RIDER FOR CODING ACCURACY AND MULTIPLE SURGICAL PROCEDURES

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

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

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

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

2. **Multiple Surgical Procedure Rules.** This paragraph applies when your Contract, Certificate or Group Health Plan covers surgical procedures performed and billed by a physician or other professional provider.

If multiple surgical procedures are performed during the same operative session, the following rules apply. In these rules, the term "primary procedure" means the most expensive procedure, i.e., the procedure with the highest amount payable under your Contract, Certificate or Group Health Plan. The term "secondary procedure" means any procedure other than the primary procedure.

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

A. **Through the Same Incision.** If covered multiple surgical procedures are through the same incision, we will provide the benefits described in your Contract, Certificate or Group Health Plan for the primary procedure. We will pay 50% of the amount we would otherwise pay under your Contract, Certificate or Group Health Plan for secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions.
We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure. Examples of incidental procedures are: an appendectomy; lysis of adhesions; splenectomy without separate pathology; biopsies of lymph nodes, liver, omentum or other organs; hernia through the same incision (umbilical, ventral, internal inguinal); secondary organs and en bloc incisions; tube enterostomies for decompression; and vasectomy accompanying prostatectomy.

B. Through Different Incisions. If covered multiple surgical procedures are performed during the same operative session but through different incisions, we will provide the following benefits:

1. The amount we would otherwise pay under your Contract, Certificate or Group Health Plan for the primary procedure; plus

2. 50% of the amount we would otherwise pay under your Contract, Certificate or Group Health Plan for all other procedures.

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

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

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: Christopher C. Booth
President and Chief Executive Officer
RIDER TO EXCLUDE COVERAGE FOR
WEIGHT LOSS SERVICES

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

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

1. Weight Loss Services Excluded. Under this Rider, the exclusion for weight loss services in your Contract, Certificate of Group Health Plan is hereby deleted in its entirety and replaced with the following:

   Weight Loss Services. We will not provide coverage for any service or care in connection with weight loss programs. We will also not provide benefits for any covered service or care set forth in your Contract, Certificate or Group Health Plan 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.

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

EXCELLUS HEALTH PLAN, INC.
doing business as
Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: Christopher C. Booth
President and Chief Executive Officer
This Rider clarifies benefits for mastectomy-related prostheses under your Contract, Certificate, Group Health Plan or Rider. All of the terms, conditions and limitations of the Contract, Certificate, Group Health Plan or Rider to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Prostheses In Connection With, Or Following, A Mastectomy.** We will provide benefits for mastectomy-related prostheses as follows:
   
   A. If your Contract, Certificate or Group Health Plan provides coverage for inpatient care provided by a hospital or other facility, our coverage of inpatient care includes coverage for prostheses and treatment of physical complications of a mastectomy, including lymphedemas; and/or
   
   B. If your Contract, Certificate or Group Health Plan provides coverage for medical and/or surgical services of physicians or other professional providers as defined in the Contract, Certificate or Group Health Plan, in addition to coverage for surgical services rendered in connection with a mastectomy, we provide coverage for prostheses and treatment of physical complications of a mastectomy, including lymphedemas; and/or
   
   C. If your Contract, Certificate or Group Health Plan, or a Rider thereto, provides coverage for prosthetic devices, our coverage of prosthetic devices includes coverage for prostheses provided in connection with, or following, a mastectomy.

   The extent of our coverage for the services described above will be determined by you and your physician.

2. **Benefits.**
   
   A. **Inpatient Hospital Care.** The coverage described in Subparagraph 1. A. above is subject to the cost-sharing requirements (deductible, coinsurance and/or copayment) that apply to inpatient hospital care.
   
   B. **Medical and/or Surgical Care.** The coverage described in Subparagraph 1. B. above is subject to the cost-sharing requirements (deductible, coinsurance and/or copayment) that apply to inpatient surgical care rendered by a physician or other professional provider.
   
   C. **Prosthetic Devices.** The coverage described in Subparagraph 1. C. above is subject to the cost-sharing requirements (deductible, coinsurance and/or copayment) that apply to prosthetic devices provided by a provider of additional health services or other authorized provider as set forth in your Contract, Certificate, Group Health Plan, or Rider thereto.
In addition to the cost-sharing requirements described above, our coverage is subject to any applicable annual or lifetime maximums set forth in your Contract, Certificate, Group Health Plan, or Rider thereto.

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

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By:  
Christopher C. Booth
President and Chief Executive Officer
RIDER FOR DEFINITION OF "MEDICALLY NECESSARY"

Issued by

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

This Rider amends your Contract, Certificate or Group Health Plan by adding or changing the definition of "Medically Necessary". All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

The provisions in your Contract, Certificate or Group Health Plan that set forth the requirement that care be Medically Necessary and describe what we consider to be Medically Necessary care are hereby deleted and replaced with Paragraphs 1 and 2 below; or, if your Contract, Certificate or Group Health Plan does not have such a provision or provisions, Paragraphs 1 and 2 below are hereby added to your Contract, Certificate or Group Health Plan.

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

We will decide whether a Service was Medically Necessary. We will base our decision in part on a review of your medical records. We will also evaluate medical opinions we receive. This could include the medical opinion of a professional society, peer review committee or other groups of physicians.

In determining if a Service is Medically Necessary, we will also consider:

A. Reports in peer reviewed medical literature;

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

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

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

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

F. Any other relevant information brought to our attention.
Services will be deemed Medically Necessary only if:

A. They are clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease;
B. They are required for the direct care and treatment or management of that condition;
C. If not provided, your condition would be adversely affected;
D. They are provided in accordance with generally-accepted standards of medical practice;
E. They are not primarily for the convenience of you, your family, the physician or another provider;
F. They are not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease; and
G. When you are an inpatient, your medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided to you in any other setting (e.g., outpatient, physician’s office or at home).

2. **Service Must Be Approved Standard Treatment.** Except as otherwise required by law, no Service rendered to you will be considered Medically Necessary unless we determine that the Service is consistent with the diagnosis and treatment of your medical condition; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative. Please see your Contract, Certificate or Group Health Plan regarding your right to an external appeal of our determination that a Service is not Medically Necessary.

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

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: Christopher C. Booth

Christopher C. Booth
President and Chief Executive Officer
This Rider adds or replaces certain benefits for mental health care under your Contract, Certificate or Group Health Plan. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. Definitions.

A. **Active Treatment.** Treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the Commissioner of Mental Health.

B. **Biologically-Based Mental Illness.** A mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Biologically-based mental illnesses are defined as the following:
   (1) Schizophrenia/psychotic disorders;
   (2) Major depression;
   (3) Bipolar disorder;
   (4) Delusional disorders;
   (5) Panic disorder;
   (6) Obsessive compulsive disorder;
   (7) Bulimia; and
   (8) Anorexia.

C. **Children with Serious Emotional Disturbances.** Persons under the age of 18 years who have diagnoses of attention deficit disorders, disruptive behavior disorders or pervasive development disorders, **and** where one or more of the following are present:
   (1) Serious suicidal symptoms or other life-threatening self-destructive behaviors;
   (2) Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
   (3) Behavior caused by emotional disturbances that placed the child at risk of causing person injury or significant property damage; or
   (4) Behavior caused by emotional disturbances that placed the child at significant risk of removal from the household.

D. **Mental Illness.** A mental, nervous or emotional condition that, in our sole judgment, has treatable behavioral manifestations and that we determine:
   (1) Is a clinically significant alteration in thinking, mood or behavior, or a combination thereof; and
   (2) Substantially or materially impairs your ability to function in one or more major life activities; and
   (3) Has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
2. **Mental Health Care.** We will provide the following coverage for Medically Necessary diagnosis and treatment of Mental Illnesses:

A. **Inpatient Care.**

   (1) **Facility Care.** When your Contract, Certificate or Group Health Plan currently covers 30 days of inpatient mental health care in a Calendar Year, or does not provide coverage for at least 30 days of inpatient mental health care in a Calendar Year, we will instead provide benefits for up to 30 days of active treatment in a Calendar Year in a hospital as defined by subdivision ten of section 1.03 of the New York Mental Hygiene Law.

   When your Contract, Certificate or Group Health Plan currently covers partial hospitalization as one-half day of inpatient care, or does not provide coverage for partial hospitalization, we will instead provide coverage for care in a licensed partial hospitalization program. A partial hospitalization program is an ambulatory program that provides a medically supervised alternative to inpatient treatment. We will only provide coverage for the care if you remain in the program for at least three continuous hours. One day’s care in a partial hospitalization program will be considered inpatient care and will be counted as one-half of a day of care toward meeting the maximum number of days of care available to you in a Calendar Year for inpatient care of Mental Illnesses.

   (2) **Services of Professionals.** When your Contract, Certificate or Group Health Plan currently covers 30 days of inpatient care by mental health professionals in a Calendar Year, or does not provide coverage for at least 30 days of inpatient care, we will provide benefits for visits by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of section 4303 (n) of the New York Insurance Law, a professional corporation or a university faculty practice corporation, for up to 30 days per Calendar Year for active treatment or for equivalent days of treatment in a partial hospitalization program; on any day of inpatient facility care or partial hospitalization covered under Subparagraph (2) above.

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

   When your Contract, Certificate or Group Health Plan provides coverage for services of Out-of-Network or Non-Participating Providers, services of both In-Network and Out-of-Network Providers or Participating and Non-Participating Providers will be counted toward the 30-day limit that applies to inpatient mental health care.

B. **Outpatient Care.**

   (1) **Facility Care.** When your Contract, Certificate or Group Health Plan currently covers 20 visits in a Calendar Year for outpatient mental health care, or does not provide coverage for at least 20 visits for outpatient mental health care in a Calendar Year, we will instead provide benefits for up to 20 visits in a Calendar Year in a facility that has an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law or in a facility operated by the Office of Mental Health.

   Our coverage for facility care under this subparagraph and for services of professionals under Subparagraph 2 below is subject, in the aggregate, to the 20-visit limit.

   (2) **Services of Professionals.** When your Contract, Certificate or Group Health Plan currently covers 20 visits in a Calendar Year for outpatient mental health care, or does not provide coverage for at least 20 visits for outpatient mental health care in a Calendar Year, we will instead provide benefits for up to 20 visits in a Calendar Year when provided by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of section 4303 (n) of the New York Insurance Law, a professional corporation or a university faculty practice corporation.
Our coverage for services of professionals under this subparagraph and for facility care under Subparagraph (1) above is subject, in the aggregate, to the 20-visit limit.

When your Contract, Certificate or Group Health Plan provides coverage for services of Out-of-Network or Non-Participating Providers, services of both In-Network and Out-of-Network Providers or Participating and Non-Participating Providers will be counted toward the 20-visit limit that applies to outpatient mental health care.

C. Biologically-Based Mental Illness; Children with Serious Emotional Disturbances. The benefits in Subparagraphs A. and B. above include benefits for Biologically-Based Mental Illness and for Children with Serious Emotional Disturbances; however, benefits for Biologically-Based Mental Illness and for Children with Serious Emotional Disturbances are not subject to any day limit for inpatient day or outpatient visit limits that apply mental health care and will be comparable to the benefits we provide for medical conditions under your Contract, Certificate or Group Health Plan. For example: if we provide benefits for unlimited days of inpatient care for medical conditions, we will provide benefits for unlimited days of inpatient care for Biologically-Based Mental Illness and for Children with Serious Emotional Disturbances; and if we provide benefits for unlimited visits for outpatient diagnosis and treatment of a medical condition, we will provide benefits for unlimited visits for outpatient diagnosis and treatment of Biologically-Based Mental Illness and for Children with Serious Emotional Disturbances.

3. Services Not Covered. Nothing in this Rider shall be construed to cover benefits for mental health services: for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or to a custodial facility for youth operated by the office of children; solely because such services are court-ordered; that are court-ordered; that are cosmetic in nature on the grounds that changing or improving an individual’s appearance is justified by the individual's mental health needs; or that are otherwise excluded under your Contract, Certificate or Group Health Plan.

4. Benefits And Cost-Sharing. Benefits under this Rider will be subject to the same cost-sharing that applies to similar medical benefits under your Contract, Certificate or Group Health Plan. For example: any Deductible, Copayment or Coinsurance that applies to inpatient care for a medical condition will apply to inpatient mental health care under this Rider; and any Deductible, Copayment or Coinsurance that applies to outpatient visits to a facility or physician will apply to outpatient mental health visits under this Rider.

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

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: Christopher C. Booth
President and Chief Executive Officer
ALLOWABLE EXPENSE RIDER

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

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

1. **Allowable Expense.** Under this Rider, the Allowable Expense definition in your Contract, Certificate or Group Health Plan is hereby deleted in its entirety and replaced with the following:

   A. **Allowable Expense.** "Allowable Expense" means the maximum amount we will pay to a Facility, Professional Provider or Provider of Additional Health Services for the services or supplies covered under this Certificate, before any applicable Deductible, Copayment and Coinsurance amounts are subtracted. Your Deductible, Copayment and Coinsurance amounts are based on the Allowable Expense, except as provided in Subparagraph (1) below. We determine our Allowable Expense as follows:

   (1) The Allowable Expense for covered services received from a Facility is the amount set by state or federal law. In the absence of state or federal law:

      (a) The Allowable Expense for covered services received from a Facility that is an In-Network Provider will be the amount we have negotiated with the Facility or the amount approved by another Blue Cross and Blue Shield Plan. However, when the Facility’s charge is less than the amount we have negotiated with the Facility, your Deductible, Copayment or Coinsurance amount will be based on the Facility’s charge.

      (b) The Allowable Expense for covered services received from a Facility that is an Out-of-Network Provider will be the lowest of:

         (i) the amount we have negotiated (or a contractor, acting on our behalf, has negotiated) with the Facility; or

         (ii) the average amount we have negotiated with our Facilities that are In-Network Providers of the same type as the Facility; or

         (iii) the amount provided to us by another Blue Cross and Blue Shield Plan; or

         (iv) the Facility’s charge.

   (2) The Allowable Expense for covered services performed by a Professional Provider or a Provider of Additional Health Services is our fee schedule amount. We assign a fee schedule amount to services or procedures based upon our review of factors such as Medicare rates, provider specialty, geographic location, and network adequacy. In the absence of a set fee schedule amount, we will determine the Allowable Expense amount taking into consideration the type of covered service, the provider specialty and the average fee schedule amount for similar covered services.

      (a) The Allowable Expense for covered services performed by an In-Network Professional Provider or an In-Network Provider of Additional Health Services will be the lowest of:

         (i) the amount listed on our fee schedule; or

         (ii) the amount approved by another Blue Cross and Blue Shield Plan; or

         (iii) the Professional Provider or Provider of Additional Health Services’ charge.
(b) The Allowable Expense for covered services of an Out-of-Network Professional Provider or an Out-of-Network Provider of Additional Health Services inside our Service Area will be the lowest of:

(i) the amount listed on our fee schedule; or

(ii) the amount we have negotiated (or a contractor, acting on our behalf, has negotiated) with the Professional Provider or Provider of Additional Health Services; or

(iii) the Professional Provider or Provider of Additional Health Services’ charge.

(c) The Allowable Expense for covered services of an Out-of-Network Professional Provider or an Out-of-Network Provider of Additional Health Services outside our Service Area will be the lowest of:

(i) the amount listed on our fee schedule; or

(ii) the amount we have negotiated (or a contractor, acting on our behalf, has negotiated) with the Professional Provider or Provider of Additional Health Services; or

(iii) the usual and customary charge as defined in Subparagraph (d) below; or

(iv) the amount provided to us by another Blue Cross and Blue Shield Plan; or

(v) the Professional Provider or Provider of Additional Health Services’ charge.

(d) The usual and customary charge is a fee or charge we determine based on provider charge data that we purchase from a New York State-approved vendor of provider pricing data.

(3) The Allowable Expense for covered services rendered by an Out-of-Network Provider in connection with an Emergency Condition is the provider’s charge.

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

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: Christopher C. Booth
President and Chief Executive Officer
RIDER FOR PARITY IN
MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

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

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

1. Treatment Limitations.

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

   We will provide coverage as follows:

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

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

(a) **Inpatient Detoxification.** We will provide coverage for active treatment for detoxification needed because of chemical dependence. This coverage is available only for services rendered in and billed by:

(i) A Facility in New York State which is certified by the Office of Alcoholism and Substance Abuse Services;

(ii) A program we recognize as a chemical dependence and abuse treatment program; or

(iii) A Facility in another state that we recognize is approved by JCAHO as an alcoholism or chemical dependence and abuse treatment program and meets the appropriate state licensing. If a government hospital meets these criteria, services rendered there will be covered unless no charge would have been made in the absence of coverage under your Contract, Certificate or Group Health Plan.

(b) **Inpatient Chemical Dependence and Abuse Rehabilitation.** We will provide coverage for the diagnosis and active treatment for rehabilitation of chemical dependence and abuse. Inpatient rehabilitation services are designed to initiate the treatment and recovery process when you are unable to participate in or comply with treatment outside a 24-hour structured treatment setting. Nursing services are available 24 hours per day. Inpatient treatment includes management of any of your physical or mental complications or co-morbidities. We will provide coverage for these medically-supervised services in a Facility that is a Plan approved provider for the active rehabilitation and treatment of chemical dependency. We will not provide benefits for intensive residential, community residential or supportive living services.

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

(1) **Mental Health.** We will provide benefits: in a facility that has an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law or in a facility operated by the Office of Mental Health; or when provided by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of section 4303 (n) of the New York Insurance Law, a professional corporation or a university faculty practice corporation.

(2) **Chemical Dependency.** We will provide coverage for outpatient visits in a Facility. Each individual visit must consist of at least one of the following: individual or group chemical dependence counseling; activity therapy; and diagnostic evaluations by a Professional Provider to determine the nature and extent of your illness or disability. We will not provide coverage for visits that consist primarily of participation in programs of a social, recreational, or companionship nature.
We will also provide coverage for family therapy. Family therapy consists of visits that include members of your family in order for your family to understand the illness of another family member and play a meaningful role in the family member’s recovery. Our coverage of a family visit will be the same regardless of the number of family members who attend the family visit. The family therapy visits may only be used by people who are covered under your Contract, Certificate or Group Health Plan.

2. **Financial Requirements.** Benefits under this Rider are subject to the predominant level of cost-sharing that applies to benefits for medical and surgical care under your Contract, Certificate or Group Health Plan. For example, the predominant level of cost-sharing (any Deductible, Copayment or Coinsurance) that applies to inpatient medical and surgical care will apply to inpatient mental health and substance use disorder benefits under this Rider; and the predominant level of cost-sharing (any Deductible, Copayment or Coinsurance) that applies to outpatient benefits (including visits to a professional provider’s office) will apply to outpatient facility visits for diagnosis and treatment of Mental Illness and substance use disorder and to visits to a professional provider’s office for diagnosis and treatment of Mental Illness under this Rider.

3. **Services Not Covered.** Nothing in this Rider shall be construed to provide benefits for mental health services: for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or to a custodial facility for youth operated by the office of children; solely because such services are court-ordered; that are cosmetic in nature on the grounds that changing or improving an individual’s appearance is justified by the individuals mental health needs; or for mental health or substance use disorder services that are otherwise excluded under your Contract, Certificate or Group Health Plan.

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

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: [Signature]

Christopher C. Booth
President and Chief Executive Officer
RIDER TO CONTINUE COVERAGE FOR YOUNG ADULTS THROUGH AGE 29

Issued by

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

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

1. Young Adults Covered through Age 29. A young adult who no longer qualifies as a dependent under your Health Plan due to age will be eligible to continue coverage through the age of 29 years by independently purchasing coverage through your Health Plan subject to the conditions described below.

2. Eligible Young Adults. A young adult is eligible to continue coverage under this Rider when the young adult:
   
   A. Is unmarried, and is the child of an employee or member insured under the Health Plan to which this Rider attaches;
   
   B. Is not, as an employee or member, insured by or eligible for coverage under any employee health benefit plan, whether insured or self-insured;
   
   C. Lives, works or resides in New York State; and
   
   D. Is not covered under Medicare.

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

3. Young Adult Coverage must be Elected. An employee, member or young adult who wishes to continue the young adult’s coverage must request the continuation in writing:
   
   A. Within 60 days following the date the young adult would otherwise lose eligibility for coverage because the young adult reached the age set forth in the Health Plan;
   
   B. Within 60 days after the young adult meets the eligibility requirements set forth in Paragraph 2 above when the young adult’s eligibility for coverage ended previously; or
   
   C. During the open enrollment period for the Health Plan.

4. Special Election Period. There is a special election period for an employee, member or young adult who wishes to continue coverage for a young adult whose coverage under the Health Plan to which this Rider attaches terminated prior to the "effective date" of the law requiring the continued coverage described in this Rider. The "effective date" is the first date on or after September 1, 2009 that the Health Plan is renewed, modified, altered or amended. The special election period continues for a period of 12 months after the effective date.
5. **Effective Date of Continued Coverage.**
   A. When continued coverage is elected under Subparagraph 3. A. above, the effective date of the continued coverage will be retroactive to the date eligibility for coverage would otherwise have ended.
   
   B. When continued coverage is elected under Subparagraph 3. B or C above, or under Paragraph 4 above, the effective date of the continued coverage will be no later than 30 days after the election is made and the first premium is paid.

6. **Premium Payment.** The first premium payment must accompany the written election in order for continued coverage to take effect. Thereafter, the employee, member or young adult electing coverage must pay the full amount of the required premium on or before the due date of each payment. Any premium received within 30 days after the due date will be considered timely.

7. **Type of Coverage.** The continued coverage will be identical to the coverage that is provided to the employee or member parent. If the parent's coverage is modified, the young adult's continued coverage will be likewise modified.

8. **Termination of Coverage.** The continued coverage will end on the earliest of the following:
   A. The date the young adult voluntarily terminates coverage under the Health Plan pursuant to its terms;
   
   B. The date the young adult’s parent is no longer covered under the Health Plan, including coverage provided under federal COBRA or state continuation of coverage laws;
   
   C. The date the young adult becomes 30 years of age;
   
   D. The date the young adult no longer meets the eligibility requirements set forth in Paragraph 2 above;
   
   E. The date to which the last premium was paid if there is a failure to make the required premium payment before the end of the 30-day grace period; or
   
   F. The date on which the group contract is terminated and not replaced.

9. **Effect of Termination of Continued Coverage.** When a young adult’s continued coverage terminates, the young adult will not have an independent right to continue coverage under federal COBRA or state continuation of coverage laws.

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

---

**EXCELLUS HEALTH PLAN, INC.**

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: [Signature]

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

1. **Continuation Period Extended to 36 Months.** Under this Rider, the 18-month period during which you are entitled to continue coverage under your Contract, Certificate or Group Health Plan pursuant to state law is extended to 36 months. The 29-month period during which you are entitled to continue coverage when determined to be disabled under Title II or XVI of the Social Security Act is also extended to 36 months.

2. **Coverage Available following Termination of federal COBRA Coverage.** Subject to the continuation provisions in your Contract, Certificate or Group Health Plan, and after you have exhausted your federal continuation benefits, you may continue coverage under the New York continuation of coverage law for: an additional 18 months when you are entitled to 18 months of federal COBRA coverage; and an additional seven months when you are entitled to 29 months of federal COBRA coverage.

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

**EXCELLUS HEALTH PLAN, INC.**

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: [Signature]

Christopher C. Booth
President and Chief Executive Officer
TIMELY CLAIMS FILING RIDER

Issued by

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

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

1. **Change in Time to File Claims.** Under this Rider the provision in your Contract or Certificate regarding the period of time within which claims should be submitted is hereby deleted in its entirety and replaced with the following:

   **Time to File Claims.** Claims for services under this Contract or Certificate must be submitted to us for payment within 12 months after you receive the services for which payment is being requested.

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

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By:  

Christopher C. Booth
President and Chief Executive Officer
RIDER FOR GRIEVANCE PROCEDURES AND TRANSITIONAL CARE

Issued by
EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

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

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

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

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

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

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

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

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

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

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

      We’ll decide the second-level grievance and notify you of our determination in writing within 30 calendar days of receipt of your second-level grievance request.
If your second-level grievance relates to an urgent matter, we’ll decide the second-level grievance and notify you of our determination by phone within 24 hours of receipt of your second-level grievance request. Written notice will follow within 24 hours of our determination.

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

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

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

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

2. Transitional Care. The following provisions apply to transitional care requirements.

A. Existing Members. If your current provider no longer participates in our network, for reasons other than quality of care, you may continue treatment with this provider for up to 90 days from the date your provider’s contractual obligation ends if you are already in an ongoing course of treatment.

B. New Members. If you’re a new Member with a life-threatening disease or condition, or a degenerative and disabling disease or condition, and the provider you currently see does not participate in our provider network, you may request to continue treatment with that provider for 60 days from your enrollment in our Health Plan.

C. Pregnant Women. If you are a pregnant woman in your second or third trimester, you may continue with your provider (in either the case of a provider termination or a new Member enrollment) through a transitional period during which you may receive any postpartum care directly related to the pregnancy.

D. Provider Requirements. To continue with a non-participating provider in any of the situations described in Subparagraphs A., B., and C. above, the provider must: accept our reimbursement as payment in full; adhere to our quality assurance program; agree to provide us with necessary medical information related to care; and follow our policies and procedures.

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

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: Christopher C. Booth
President and Chief Executive Officer
DOMESTIC PARTNER RIDER FOR CALIFORNIA RESIDENTS

Issued by

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

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

1. **California Residency Required.** This Rider only applies to residents of the State of California. You, the Subscriber, are only entitled to cover your domestic partner as described in this Rider if you reside in California.

2. **Who are Domestic Partners?** Domestic partners are two persons who are registered as domestic partners, which means they have filed a "Declaration of Domestic Partnership" with the California Secretary of State. You are eligible to register as domestic partners if you meet the following criteria: you are both 18 years of age or older; you are unrelated by blood in a way that would bar marriage in the State of California; you reside together; you are persons of the same sex, or one or both of you is over the age of 62; and neither of you is married to someone else or is in a domestic partnership with someone else.

3. **Domestic Partner Coverage.** Coverage of your, the Subscriber’s, domestic partner will become effective and terminate according to the provisions in your Health Plan that apply to coverage of the Subscriber’s spouse. All of the terms of your Health Plan that apply to a spouse will apply to your domestic partner, except that according to federal law, domestic partners are not eligible for continuation of coverage under COBRA.

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

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: [Signature]
Christopher C. Booth
President and Chief Executive Officer
RIDER FOR NEW CONTRACT AFTER TERMINATION

Issued by

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

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

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

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

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

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

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

1. **Autism Spectrum Disorder.** We will provide coverage for the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this Rider, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

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

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

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

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

   C. **Behavioral Health Treatment.** We will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed provider. We will provide coverage for applied behavior analysis when provided by an applied behavior analysis provider as
defined and described in 11 NYCCR 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.

Our coverage of applied behavior analysis services is limited to 680 hours per Member per Contract Year.

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

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

F. Pharmacy Care. We will provide coverage for prescription drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under title eight of the Education Law when prescription drugs are otherwise covered under your Health Plan. Our coverage of such prescription drugs is subject to all the terms, provisions, and limitations that apply to prescription drug benefits under your Health Plan.

We will not provide coverage for any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law.

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

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

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: Christopher C. Booth
President and Chief Executive Officer
DENTAL CARE EXCLUSION RIDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

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

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

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

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By:  Christopher C. Booth
Christopher C. Booth
President and Chief Executive Officer
RIDER FOR INTER-PLAN ARRANGEMENTS DISCLOSURE

Issued by
EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

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

Out-of-Area Services. We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of our 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 our Service Area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "Participating Providers" or "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 Non-Participating (or Out-of-Network) Providers. Our payment practices in both instances are described below.

1. BlueCard® Program. Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating/In-Network Providers.

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

A. The provider’s billed covered charges for your covered services; or
B. The negotiated price that the Host Blue makes available to us. This negotiated price will be one of the following:
   (1) Often, a simple discount that reflects an actual price that the Host Blue pays to your provider;
   (2) Sometimes, an estimated price that takes into account special arrangements with your provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges; or
   (3) Occasionally, an average price, based on a discount that results in expected average savings for similar types of providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, 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 we use 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, we would then calculate your liability for any covered healthcare services according to applicable law.
2. **Calculation of Member Liability for Services of Non-Participating/Out-of-Network Providers outside our Service Area.** The Allowable Expense definition in your Health Plan, as amended from time-to-time, describes how our payment (the “Allowable Expense”) for covered services of Non-Participating/Out-of-Network Providers outside our Service Area is calculated. The Allowable Expense may be based upon the amount provided to us by the Host Blue or the payment we would make to Non-Participating/Out-of-Network Providers inside our Service Area. Regardless of how the Allowable Expense is calculated, you will be liable for the amount, if any, by which the provider’s actual charge exceeds the Allowable Expense, which amount is in addition to any other cost sharing (Deductible, Copayment or Coinsurance) required by your Health Plan.

**EXCELLUS HEALTH PLAN, INC.**

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: [Signature]

Christopher C. Booth
President and Chief Executive Officer
RIDER FOR INFERTILITY TREATMENT SERVICES
Issued by
EXCELLUS HEALTH PLAN, INC.
A nonprofit independent licensee of the BlueCross BlueShield Association

The benefits of this Rider are subject to any applicable deductible, copayment, or coinsurance provisions of your Contract, Certificate or Group Health Plan for similar services. For example, any hospital inpatient deductible, copayment or coinsurance will also apply to inpatient benefits provided under this Rider; any deductible, copayment or coinsurance applicable to physician services will also apply to physician services under this Rider; and any prescription drug deductible, copayment or coinsurance will also apply to prescription drugs under this Rider.

1. **Infertility Defined.** For the purposes of this Rider, infertility has the meaning set forth in regulations of the New York State Insurance Department. In general, infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse, as further defined in regulations. 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.

2. **Coverage Provided For Individuals 21 To 44 Years Of Age.** The benefits provided by this Rider are available only to Members covered under the Contract, Certificate or Group Health Plan who are between the ages of 21 and 44 as of the date the services are rendered.

3. **Coverage Only Provided For Appropriate Candidates.** Coverage under this Rider will only be provided to "Appropriate Candidates" within the age group described in Paragraph 2. An Appropriate Candidate is an individual determined to be an Appropriate Candidate by the treating physician, in accordance with the standards and guidelines established and adopted by the New York State Insurance Department by regulation.

4. **Covered Services.** Subject to the other provisions of this Rider and your Contract, Certificate or Group Health Plan, we will provide benefits under this Rider for:

   A. Medical and surgical procedures, such as artificial insemination, intrauterine insemination, and dilation and curettage ("D & C"), including any required inpatient or outpatient hospital care, that would correct malformation, disease or dysfunction resulting in infertility; and

   B. Services in relation to diagnostic tests and procedures necessary:

      (1) To determine infertility; or

      (2) In connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered by this Rider are:
• Hysterosalpingogram;
• Hysteroscopy;
• Endometrial biopsy;
• Laparoscopy;
• Sono-hysterogram;
• Post-coital tests;
• Testis biopsy;
• Semen analysis;
• Blood tests;
• Ultrasound; and
• Other Medically Necessary diagnostic tests and procedures, unless excluded by law; and

C. Prescription drugs approved by the FDA specifically for the diagnosis and treatment of infertility, which are not related to any excluded services. This prescription drug benefit is subject to the same conditions, exclusions, limitations and requirements that apply to all other prescription drugs under your Contract, Certificate or Group Health Plan, except as specifically modified by this Rider.

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

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

7. **Deductibles, Copayments And Coinsurance.** The benefits of this Rider are subject to any applicable deductible, copayment, or coinsurance provisions of your Contract, Certificate or Group Health Plan for similar services. For example, any hospital inpatient deductible, copayment or coinsurance will also apply to inpatient benefits provided under this Rider; any deductible, copayment or coinsurance applicable to physician services will also apply to physician services under this Rider; and any prescription drug deductible, copayment or coinsurance will also apply to prescription drugs under this Rider.

8. **Services Must Be Medically Necessary.** We will not provide benefits for a service to diagnose or treat infertility if we determine, in our sole judgment, that the service was not "medically necessary," as that term is defined in your Contract, Certificate or Group Health Plan.

9. **Excluded Services.** We will not pay benefits for any services related to or in connection with:
   • In-Vitro Fertilization;
   • Gamete Intra-Fallopian Transfer (GIFT);
   • Zygote Intra-Fallopian Transfer (ZIFT);
   • Reversal of elective sterilizations, including vasectomies and tubal ligations;
   • Sex change procedures;
   • Cloning;
   • Sperm banking and donor fees associated with artificial insemination or other procedures; and
10. **Experimental Procedures Not Covered.** This Rider does not cover services or procedures that we, in our sole judgment, determine to be experimental, according to standards and guidelines that are no less favorable than those established and adopted by the American Society for Reproductive Medicine. You may appeal our determination that a service or procedure is experimental to an external appeal agent as described in the External Appeal provision of your Contract, Certificate or Group Health Plan.

11. **Waiting Period.** Coverage under this Rider is subject to the waiting period for pre-existing conditions, if any, under your Contract, Certificate or Group Health Plan.

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

EXCELLUS HEALTH PLAN, INC.

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: [Signature]

Christopher C. Booth
President and Chief Executive Officer
PATIENT PROTECTION AND AFFORDABLE CARE ACT RIDER

Issued by

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

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

1. Emergency Services.
   A. Emergency Condition Defined. The definition of Emergency Condition in the Health Plan is hereby deleted in its entirety and replaced with the following:
      
      Emergency Condition. A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
      
      (1) Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
      
      (2) Serious impairment to such person’s bodily functions;
      
      (3) Serious dysfunction of any bodily organ or part of such person; or
      
      (4) Serious disfigurement of such person.

   B. Emergency Services Defined. The following definition is hereby added to your Health Plan:
      
      Emergency Services. A medical screening examination (consisting of a clinical history, physical examination, diagnostic testing, and therapeutic interventions such as intravenous fluids and intravenous antibiotics) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required "to stabilize" the patient.
      
      "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility or to deliver a newborn child (including the placenta).

   C. Prior Approval. Emergency Services are not subject to prior authorization requirements.

   D. Cost Sharing. Any Copayment or Coinsurance requirement in the Health Plan that applies to Emergency Services provided by an Out-of-Network Provider that differs from the Copayment or Coinsurance required for Emergency Services provided by an In-Network Provider is hereby deleted and replaced with the Copayment or Coinsurance requirement, if any, applicable to Emergency Services provided by In-Network Providers.
E. **Your Payments.** You are responsible for any applicable Deductible, Copayment, or Coinsurance. We will ensure that you are held harmless for any Out-of-Network Provider charges that exceed your Copayment.

2. **Preventive Services.** To the extent items and services in the sources referenced below are not already covered services for adults and children under the Health Plan, benefits for the items and services are hereby added to the Health Plan:

   A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;
   
   B. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations; and
   
   C. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").

Except as otherwise provided below with respect to contraceptive services, the preventive services referenced above shall be covered in full when received from In-Network Providers. The preventive services referenced above are only covered when provided by In-Network Providers. Cost sharing (e.g., Copayments, Deductibles, Coinsurance) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

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

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

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

3. **Annual Limits.** Any annual dollar limit under the Health Plan that applies to Essential Benefits, whether such annual limit applies only to an Essential Benefit or includes Essential Benefits and other benefits, is hereby deleted. "Essential Benefits" include ambulatory care; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative care; laboratory services; preventive and wellness services and chronic disease management; pediatric services including oral and vision care; and any other services set forth in regulations issued pursuant to the Patient Protection and Affordable Care Act.

4. **Pre-Existing Conditions.** Under this Rider, the provision, if any, in the Health Plan that allows us to exclude or otherwise limit coverage for Pre-Existing Conditions until a Member has been continuously covered under the Health Plan for a stated period is hereby deleted in its entirety with respect to all Members.

5. **Lifetime Dollar Limits Deleted.** Any lifetime dollar limit under the Health Plan is hereby deleted in its entirety.
6. **Dependent Children Covered to Age 26.** If the Health Plan makes coverage of dependents available, this Rider applies to coverage of children as follows:

A. If you selected other than individual coverage, your children who are under the age of 26 may be covered under the Health Plan. Coverage lasts until the end of the month in which the child turns 26 years of age. Your children need not be financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as students; or unmarried. Children-in-law (spouses of children) and grandchildren are not covered under this Rider.

Coverage for Your child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attaining age 26 shall not terminate while the Health Plan remains in effect and the child remains in such condition, if You submit proof of Your child’s incapacity within 31 days of Your child’s attaining age 26.

B. "Children" include your natural children, a legally adopted child; a step child; and a child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption period. Coverage lasts until the end of the month in which the child turns 26 years of age.

C. A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order is covered. Coverage lasts until the end of the month in which the child turns 26 years of age.

D. The provisions of any Rider to the Health Plan that extends coverage for young adults through age 29 (for example, the provision requiring that the child be unmarried) shall remain in effect for children ages 26 through 29 and are not changed by provisions set forth above in this Paragraph 6 that apply to children under the age of 26.

7. **Utilization Review.** The following changes are made to the Utilization Review paragraph in the Health Plan:

A. The provision dealing with prospective urgent care claims in the Utilization Review paragraph in the Health Plan is hereby deleted in its entirety and replaced with the following:

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

B. The provision dealing with concurrent reviews in the Utilization Review paragraph in the Health Plan is hereby deleted in its entirety and replaced with the following:

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

For concurrent reviews that involve urgent matters, we will make a determination and provide notice to you (or your designee) and your provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified above for prospective urgent claims.
If we have approved a course of treatment, we will not reduce or terminate the approved services unless we have given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

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

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

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

**External Appeal.**

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

You may have the right to an expedited external appeal if your attending physician attests that a delay in providing the requested service would pose an imminent or serious threat to your health or jeopardize your life, health, or ability to regain maximum function. Also, you have the right to an expedited external appeal in connection with adverse determinations concerning an admission, availability of care, continued stays, or health care services for which you received emergency services, but have not been discharged from a facility. The timeframes for determining expedited external appeals are shorter than the timeframes for standard external appeals.

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

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

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

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

To be eligible for external appeal, the final adverse determination issued through the first level of the internal appeal process must be based on a determination that the requested service does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or that the requested service is experimental or investigational. You do not have the right to an external appeal of any other determinations, even if those other determinations affect your coverage.
C. **Conditions for External Appeals of Determinations of Medical Necessity.** You may request an external appeal of a final adverse determination of Medical Necessity issued through the first level of the internal appeal process if you meet the conditions of this subparagraph and the general requirements of Subparagraph B above. The provisions of this subparagraph apply only to external appeal of Medical Necessity determinations.

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

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

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

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

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

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

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

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

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

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

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

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

1. **Rare Disease Defined.** A condition or disease that:
   - Is currently, or has been, subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or
   - Affects less than 200,000 United States residents per year; and
   - For which there does not exist a standard health service or procedure covered by your Health Plan that is more clinically beneficial than the requested health service or treatment.
(2) **Certifying Physician.** The physician must be a licensed, board-certified or board-eligible physician who specializes in the area of practice appropriate to treat your Rare Disease.

(3) **Conditions for External Appeals Involving Rare Disease Treatment.** In order to request an external appeal under this subparagraph, the following conditions must be met:

(a) **Certification.** A physician, other than your treating physician, who meets the requirements in Subparagraph (2) above, must certify in writing that:

   (i) You have a Rare Disease as defined above.

   (ii) That your Rare Disease is currently, or has been, subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or affects less than 200,000 United States residents per year.

   (iii) Based on the physician’s credible experience, there is no standard treatment that is likely to be clinically more beneficial to you than the requested health service or procedure; the requested health service or procedure is likely to benefit you in the treatment of your Rare Disease; and that such benefit to you outweighs the risks of such health service or procedure.

(b) **Required Disclosure by the Certifying Physician.** The certifying physician must disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for external appeal of a denial of your Rare Disease treatment.

(c) **Institutional Review Board.** If the provision of the requested health service or procedure at a facility requires prior approval of an institutional review board, you or your designee must submit such approval as part of the external appeal application.

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

(1) For services denied as not Medically Necessary, we will treat the service as Medically Necessary and provide coverage subject to all other conditions of the Health Plan.

(2) For services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of the Health Plan.

(3) For services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of the Health Plan. We are not required to pay for drugs or devices that are the subject of the clinical trial.

(4) For services denied for treatment of a Rare Disease, we will provide coverage for the requested health service or procedure, subject to all other conditions of the Health Plan, when a majority of the panel of external appeal reviewers determines, based on the certification described in Subparagraph F.(3)(a) above, and such other evidence as you, your designee or your attending physician may present, that the requested health service or procedure is likely to benefit you in the treatment of your Rare Disease and that such benefit outweighs the risks of such health service or procedure.

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

H. **Requesting an External Appeal.** If you meet the conditions described above, you may request an external appeal by filing a standard external appeal request form with the New York State Department of Financial Services. We will send a standard request form to you when we have made a final adverse determination at the first level of the internal appeal process. You or your physician may obtain additional standard request forms at any time from the State Department of Financial Services or by contacting us.
You must file your request for an external appeal with the State Department of Financial Services within four months of receiving a final adverse determination as a result of the first level appeal process, or within four months of receiving a letter from us waiving the internal review process. We do not have the authority to grant extensions of this deadline.

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

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

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

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

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

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

1. **Waiting Period Waived.** We will waive any waiting period for Pre-existing Conditions that applies to services otherwise covered under your Certificate. You will not have to satisfy a waiting period before you have coverage for Pre-existing Conditions.

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

EXCELLUS HEALTH PLAN, INC.
doing business as
Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: [Signature]
Christopher C. Booth
President and Chief Executive Officer
RIDER FOR
INPATIENT MENTAL HEALTH CARE

Issued by

EXCELLUS HEALTH PLAN, INC.

A Nonprofit Independent Licensee of the BlueCross BlueShield Association

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

1. Mental Health Care. We will provide coverage for inpatient care that is for acute mental health care for up to 30 days in a Calendar Year. We will also provide coverage for care in a licensed night or day care program for mental health care when it is provided in a licensed night care or day care center maintained by the Facility on its premises and for overnight accommodations in a licensed night care center. A day/night care center is an ambulatory treatment center that provides a medically supervised alternative to inpatient treatment. We will only provide coverage for the care if you remain in the night care or day care center for at least 3 continuous hours. One night’s care in a night care center or one day’s care in a day care center will be considered inpatient care and will be counted as one-third of a day of Facility care toward meeting the maximum 30 days of inpatient care available to you in a Calendar Year for mental health care.

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

In-Network and Out-of-Network Benefits for mental health care will both be counted toward the 30-day limit.

2. Benefits.

In-Network. In-Network Benefits are subject to a $100 Copayment per Single Confinement for inpatient mental health care. A Single Confinement means one or more inpatient admissions to a Facility. When you are admitted to a Facility after at least 90 days during which you have not been confined for the same condition in any Facility you will begin a new Single Confinement.

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

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

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: Christopher C. Booth
President and Chief Executive Officer
RIDER FOR
INPATIENT CHEMICAL DEPENDENCE DETOXIFICATION
AND REHABILITATION

Issued by
EXCELLUS HEALTH PLAN, INC.
A Nonprofit Independent Licensee of the BlueCross BlueShield Association

This Rider adds certain benefits for inpatient chemical dependence detoxification and rehabilitation to your Contract, Certificate or Group Health Plan. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. Inpatient Detoxification. We will provide for active treatment for detoxification needed because of chemical dependence up to a maximum of seven (7) days per Calendar Year. This coverage is available only for services rendered in and billed by:

   (1) A facility in New York State which is certified by the Office of Alcoholism and Substance Abuse Services;

   (2) A program we recognize as a chemical dependence and abuse treatment program; or

   (3) A facility in another state, which we recognize, that is approved by the Joint Commission on Accreditation of Health Care Organizations as a chemical dependence and abuse treatment program and meets the appropriate state licensing. If a government hospital meets these criteria, services rendered there will be covered unless no charge would have been made in the absence of insurance.

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

In-Network and Out-of-Network Benefits for inpatient detoxification will both be counted toward the 7-day limit.

2. Inpatient Chemical Dependence and Abuse Rehabilitation. The benefit for treatment and diagnosis of chemical dependence and abuse includes active treatment for rehabilitation. We will provide covered services for a 24-hour; live-in program of services; in a Facility that is a Plan-approved provider for active rehabilitation and treatment of chemical abuse. The program is non-medical and provides rehabilitation and treatment for chemical abuse or dependence in a controlled environment. We will not provide benefits for care in a non-therapeutic residential facility.

Benefits are available for up to a maximum of 30 days per Calendar Year and two admissions per lifetime. This aggregate limitation does not apply to detoxification.

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

In-Network and Out-of-Network Benefits for inpatient chemical dependence and abuse rehabilitation will both be counted toward your annual and lifetime limits.
3. **Benefits.**

   **In-Network.** In-Network Benefits for Facility care are subject to a $100 Copayment per Single Confinement. A Single Confinement means one or more inpatient admissions to a Facility. When you are admitted to a Facility after at least 90 days during which you have not been confined for the same condition in any Facility, you will begin a new Single Confinement. In-Network Benefits for Professional Provider medical visits are covered in full.

   **Out-of-Network.** Out-of-Network Benefits for Facility and Professional Provider medical visits are covered at 70% of the Allowable Expense, after Deductible.

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

---

**EXCELLUS HEALTH PLAN, INC.**

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: [Signature]

Christopher C. Booth
President and Chief Executive Officer
This Rider adds certain benefits for preventive care to your Certificate of Coverage. All of the terms, conditions and limitations of the Certificate to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. **Adult Immunizations.** Under this Rider, we will provide coverage for adult immunizations (for example, influenza and meningococcal vaccinations) when administered in a Professional Providers office according to guidelines based on: the Report of the US Preventive Services Task Force; and the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

2. **Benefits.**

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

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

**EXCELLUS HEALTH PLAN, INC.**
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647

By: [Signature]

Christopher C. Booth
President and Chief Executive Officer
RIDER FOR ROUTINE LABORATORY, PATHOLOGY AND IMAGING SERVICES

Issued by

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

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

1. **Routine Defined.** Services or procedures are "routine" when they are provided to screen for illness in asymptomatic Members.

2. **Routine Laboratory and Pathology Services.** We will provide coverage for routine laboratory and pathology services provided in the outpatient department of a Facility or in a Professional Provider’s office.

   - **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.

3. **Routine Imaging Procedures.** We will provide coverage for routine x-ray, ultrasound and other imaging procedures performed in the outpatient department of a Facility or in a Professional Provider’s office.

   - **In-Network.** In-Network Benefits are subject to a $20 Copayment.
   - **Out-of-Network.** Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible.

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

EXCELLUS HEALTH PLAN, INC.

doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By: [Signature]

Christopher C. Booth
President and Chief Executive Officer
PULMONARY REHABILITATION RIDER

Issued by

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

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

1. **Benefits for Pulmonary Rehabilitation Added.** We will provide coverage for Medically Necessary patient assessment and formal training and education phases of pulmonary rehabilitation programs provided in the outpatient department of a Facility or in a Professional Provider’s office. Services must be rendered by an approved pulmonary rehabilitation program and recommended by the Member’s cardiologist or other Professional Provider. We will provide coverage for up to 36 visits per lifetime.

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

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

2. **Benefits for Respiratory Therapy Deleted.** The references to "respiratory therapy" in the Covered Therapies paragraphs in the Outpatient Care and Professional Services Sections of your Certificate are hereby deleted. We will not provide coverage for respiratory therapy services provided in the office or outpatient department.

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

EXCELLUS HEALTH PLAN, INC.
doing business as

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647

By:  
Christopher C. Booth
President and Chief Executive Officer
RI​DER FOR
DURABLE MEDICAL EQUIPMENT, EXTERNAL PROSTHETICS, ORTHOTICS
AND MEDICAL SUPPLIES

Issued by
EXCELLUS HEALTH PLAN, INC.
A Nonprofit Independent Licensee of the BlueCross BlueShield Association

This Rider adds certain benefits for durable medical equipment, external prosthetics, orthotics and medical supplies to your Contract, Certificate or Group Health Plan. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

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

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

   No coverage is available 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.

   **Prior Approval.** You must obtain our prior approval for all durable medical equipment that costs more than $200.00. See Section Three of your Contract, Certificate or Group Health Plan for our prior approval procedures.

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

   A prosthetic device is an artificial organ or body part, including, but not limited to, artificial limbs and eyes. Prosthetic devices include, for example, the following that are used to replace functioning natural body parts: artificial arms, legs, and eyes; ostomy bags and supplies required for their use; and catheters. Prosthetic devices do not include, for example: hearing aids; eyeglasses; contact lenses; medical supplies; wigs; or foot orthotics such as arch supports or insoles, regardless of the Medical Necessity of those items. Dentures or other devices used in connection with the teeth are also not covered unless required due to 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; or the additional cost of deluxe items, unless approved in advance by the Medical Director. We will not provide coverage for delivery or service charges, or for routine maintenance related to prosthetic devices.

3. **Orthotic Devices.** We will provide coverage for orthotic devices that are rigid or semi-rigid (having molded plastic or metal stays) and their replacements when the devices are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness. Orthotic devices include orthopedic braces and custom-built supports. Your physician must order the orthotic device for your condition before its purchase. Although we require that a physician prescribe the device, this does not mean that we will automatically determine you need it. We alone will determine if the orthotic device is Medically Necessary. We will only provide benefits for an orthotic device that we determine can adequately meet the needs of your condition at the least cost.

   We will not pay for: arch supports, foot inserts and other foot devices, even if custom-fitted; or orthopedic shoes.

4. **Medical Supplies.** We will provide coverage for disposable medical supplies when you are not an inpatient in a Facility and we determine that 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; tracheostomy supplies; and compression stockings.

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

5. **Benefits.** We will pay a maximum of $15,000.00 per Member per Calendar Year for external prosthetics and orthotics. In-Network and Out-of-Network Benefits will both be counted toward the Calendar Year maximum.

   **In-Network.** In-Network Benefits are covered at 80% of the Allowable Expense, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

   **Out-of-Network.** Out-of-Network Benefits are covered at 70% of the Allowable Expense, after Deductible. You are responsible for any additional charge for the purchase of a deluxe item that is not Medically Necessary.

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

Under federal law we are required to notify you of the following benefits under your contract(s) or certificate(s) in connection with mastectomies. **PLEASE NOTE THAT YOUR BENEFITS UNDER YOUR CONTRACTS OR CERTIFICATES HAVE NOT CHANGED.**

- **If your contract or certificate provides benefits for inpatient hospital care:** New York State law mandates coverage for the inpatient hospital stay that you and your attending physician determine is appropriate for you after undergoing a lymph node dissection or lumpectomy for the treatment of breast cancer, or after a covered mastectomy.

- **If your contract provides medical and/or surgical benefits:** New York State and federal law mandate coverage for professional provider services, as determined by you and your attending physician, in connection with the following:
  - Reconstruction of the breast on the breast on which the mastectomy was performed;
  - Surgery and reconstruction of the other breast, to produce a symmetrical appearance; and
  - Prostheses and physical complications at all stages of mastectomy, including lymphedema.

The benefits are subject to the referral and cost-sharing (deductible, copayment, and/or coinsurance) requirements of your contract, as described in the contract(s) or certificate(s) or rider describing these benefits.
THE NEW YORK CONSUMER GUIDE TO HEALTH INSURERS

The New York Consumer Guide to Health Insurers evaluates the performance of HMOs and other insurers.

TO OBTAIN YOUR FREE COPY, WRITE TO:

New York State Department of Financial Services
Publications Unit
Agency Building One, 5th Floor
Albany, New York  12257

Or e-mail your request to:
Publicat@dfs.ny.gov

Guides are also available through the
New York State Department of Financial Service’s Website:
www.dfs.ny.gov

Please send a copy of the current New York Consumer Guide to Health Insurers to:

NAME:  ________________________________
ADDRESS: __________________________________
CITY/STATE: __________________________________
ZIP CODE:  ________________________________
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

This notice takes effect April 14, 2003.

OUR COMMITMENT TO YOUR PRIVACY

We understand that medical information about you and your health is personal. We are committed to safeguarding your protected health information (PHI).

PHI is any information that can identify you as an individual and your past, present or future physical or mental health condition.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. The law requires us to:

- make sure that PHI that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to PHI about you; and
- follow the terms of the notice that is currently in effect.

OUR LEGAL DUTY

We (Excellus BlueCross BlueShield) are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning PHI. We must follow the privacy practices that are described in this notice while it is in effect, including notification should there be a breach of your unsecured PHI.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the contact information at the end of this notice.
Uses and Disclosures of Nonpublic Personal Information

Nonpublic Personal Information is information you give us on your enrollment form, claim forms, premium payments etc. For example: names, member identification number, social security number, addresses, type of health care benefits, payment amounts, etc.

We will not give out your nonpublic personal information to anyone unless we are permitted to do so by law or have received a signed authorization form from the member. You may revoke this authorization in writing by completing an authorization cancellation form at any time. This revocation will not affect any actions we took in reliance on your authorization before your authorization cancellation form was processed.

Uses and Disclosures of Medical Information

The following categories describe different purposes for which we use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. If we need to use or disclose your PHI in any other way, we will obtain your signed authorization before our use or disclosure. You may revoke this authorization in writing by completing an authorization cancellation form at any time. This revocation will not affect any actions we took in reliance on your authorization before your authorization cancellation form was processed.

**Treatment:** We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to doctors or hospitals involved in your care. For example, we may disclose your medications to an emergency room physician so that he/she can avoid dangerous drug interactions. This allows providers to manage, coordinate and administer treatment.

**Payment:** We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use and disclose PHI to collect premiums, to determine our responsibility to pay claims or to notify members and providers of our claim determinations. We may disclose PHI to providers to assist them in their billing and collection efforts. We may also disclose PHI to other insurance companies to coordinate the reimbursement of health insurance benefits. For example, we may disclose PHI to an automobile no-fault insurance company to determine responsibility for claim payment. Also, if you have health insurance through another insurance company, we may disclose PHI to that other health insurance company in order to determine which company holds the responsibility for your claims.

**Healthcare Operations:** We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use and disclose PHI for purposes of performing our healthcare operations. Our healthcare operations include using PHI to determine premiums, to conduct quality assessment and improvement activities, to engage in care coordination or case management, to determine eligibility for benefits. For example, we may use or disclose PHI when working with accreditation agencies that monitor and evaluate the quality of our benefit programs.

**To You:** We must disclose your PHI to you, as described in the Individual Rights section of this notice, below. We may also use and disclose PHI to tell you about recommended possible treatment options or alternatives or to tell you about health related benefits or services that may be of interest to you.
To Family and Friends: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. If you agree or, if you are unable to agree when the situation, (such as medical emergency or disaster relief), indicates that disclosure would be in your best interest, we may disclose PHI to a family member, friend or other person. In an emergency situation, we will only disclose the minimum amount necessary.

To Our Business Associates: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. A business associate is defined as someone that assists us in managing our business. For example, a professional that reviews the quality of our products and services. We may disclose PHI to another company that helps us manage our business. For example, we may disclose PHI to a company that performs case reviews to ensure our members receive quality care. These business associates are required to sign a confidentiality agreement with us that limits their use or disclosure of the PHI they receive.

To Plan Sponsors: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. A plan sponsor is defined as the employer or employee organization that establishes and maintains the employee’s benefit plan. If you are enrolled in a group health plan, we may disclose PHI to the plan sponsor to permit the plan sponsor to perform plan administrative functions. For example, the cost analysis of the benefit program. Before PHI is disclosed to your plan sponsor, we will receive certification from the plan sponsor that appropriate amendments have been made to group health plan document(s) and the plan sponsor agrees to limit their use or disclosure of this information to plan administration functions only.

Research: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use or disclose PHI for research purposes in limited circumstances. For example, a research project may involve comparing the health and recovery of all members who received one medication to those who received another medication for the same condition. All research projects are required to obtain special approval.

Coroners, Medical Examiners and Funeral Directors: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may release PHI to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release PHI about deceased members to funeral directors in order for the funeral directors to carry out their duties.

Organ Donation: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, to facilitate organ or tissue donation and transplantation. This may include a living donor as well as a deceased donor.

Public Health and Safety: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose PHI to a government agency authorized to oversee the healthcare system or government programs or its contractors, and to public health authorities for public health purposes.

Victims of Abuse, Neglect or Domestic Violence: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.
**Required by Law:** We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use or disclose PHI when we are required to do so by law. For example, we must disclose PHI to the U.S. Department of Health and Human Services upon request to determine whether we are in compliance with federal privacy laws.

**Process and Proceedings:** We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose PHI to law enforcement officials.

**Law Enforcement:** We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to a law enforcement official investigating a suspect, fugitive, material witness, crime victim or missing person. We may disclose PHI of an inmate or other person in lawful custody of a law enforcement official or correctional institution under certain circumstances.

**Military and National Security:** We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose to the military, PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence, and other national security activities.

**Marketing and Fundraising:** We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. To the extent we use PHI for marketing or fundraising purposes, you will be contacted by us and have the right to opt out of receiving these communications from us and our use of your information for such purposes.

**Genetic Nondiscrimination Act (GINA):** We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We will not disclose your PHI containing genetic information for underwriting purposes. GINA expressly prohibits the use or disclosure of genetic information for these purposes.

**Breach of Unsecured Information:** We will notify you should there be a breach of unsecured information. We are required to notify you if there is any acquisition, access, use, or disclosure of your unsecured PHI that compromises the security or privacy of your PHI.

**Psychotherapy Information:** We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. Should it be applicable that your psychotherapy notes be included in an appropriate use or disclosure of information, in most instances, we are required to obtain your authorization for the release of this information.

**Individual Rights**

**Access:** You have the right to inspect and/or copy your PHI, with limited exceptions such as information a licensed health care professional, exercising professional judgment, determines that providing access is reasonably likely to endanger the life, physical safety or cause someone substantial harm. You may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us. If you request copies, we reserve the right to charge you a reasonable fee for each copy, plus postage if the copies are mailed to you.
**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your PHI. The list will not include disclosures we made for the purpose of treatment, payment, healthcare operations, disclosures made with your authorization, or certain other disclosures. To request a disclosure accounting you may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us. The request may not exceed a six year time period. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed and the reason for the disclosure. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction Requests:** You have the right to request that we place additional restrictions on our use or disclosure of your PHI. As permitted by law, we will not honor these requests, as it prohibits us from administering your benefits.

**Confidential Communication:** You have the right to request that we communicate with you confidentially about your PHI. We will honor a request to communicate to an alternative location if you believe you would be endangered if we do not communicate to the alternative location. We must accommodate your request if it is reasonable and specifies the alternative location. To request a form to be completed and returned to us, you may contact us using the telephone number on the back of your identification card.

**Amendment:** You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or if we determine the information is accurate. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be attached to the information you wanted amended. You may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us.

**Electronic Notice:** If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the contact information at the end of this notice to obtain this notice in written form.

---

**Safeguards**

It is our policy to keep all information about you confidential in all settings. It is so important to us that we take the following steps:

- our employees sign an agreement to follow our Code of Business Conduct;
- our employees are required to complete our privacy training program;
- we have implemented the necessary sanctions for violation of our privacy practices;
- we have a privacy oversight committee that reviews our privacy practices;
- we have a security coordinator to detect and prevent security breaches;
- all computer systems that contain personal information have security protections; and
- we randomly check provider offices on a routine basis to ensure that medical records are kept in secure locations.
Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the contact information at the end of this notice.

If you are concerned that we may have violated your privacy rights, as described above, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us confidentially communicate with you at an alternative location, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Rights or Questions:
Contact Office: Customer Service
Phone: Please call the telephone number on your identification card.

Privacy Complaints:
Contact Office: Privacy Officer
Address: 333 Butternut Dr.
          Dewitt, NY 13214-1803
Phone: 1-866-584-2313
E-mail: privacy.officer@excellus.com
FEH BOCES
MAIL INSIDE AN ENVELOPE
DO NOT ATTACH A LABEL
DIRECTLY TO THIS -