BlueShield of Northeastern New York
30 Century Hill Drive • Latham, New York 12110

Fulmont Health Trust - Wells
Steve Schloicka
234 Lincoln Street
Gloversville, NY 12078

July 2013

Dear Steve Schloicka,

Thank you for offering BlueShield of Northeastern New York coverage to your organization.

Why you're receiving this/these plan document(s)	Enclosed is your copy of the subscriber contract for one of the plans your group offers to your employees.
What you need to know	As part of our ongoing effort to provide cost-effective administration of our health plans, we no longer print and mail contracts to individual subscribers enrolled in a group plan. Per our Master Group Agreement, it is your responsibility to ensure each of your employees receive a copy of the contract for their plan. However, we will continue to send contracts to direct bill COBRA group members. Please use your billing statement to determine which of your employees need to receive a copy of this contract. We have included a sample billing statement to help you locate the information you need. We are working toward making contracts and member guides available online for members to access. We'll keep you informed as we progress with these member enhancements.
What you need to do	Please provide a copy of the contract to the appropriate employees. If you have any questions about this contract or would like more information about online resources currently available for members, please contact your account executive.

Thank you for choosing BlueShield. We value your membership.

Lee Castleman
Director, Large Business

Enc

These group, class and plan numbers will use this contract.

Group Number	Class Number	Plan Number	Product ID
00969603	0003	EPO5N000	H6CD1246

Verifying Contracts to Your Billing Statement

Look for the contract code at the top of page two on the contract's Welcome page.

Sample Contract Code:

12345678 0001 NCB1Y000

1. 12345678 - The first eight-digit number is your group number.
2. 0001- The following four digits show the class number.
3. NCB1Y000 - The final eight characters (letters and numbers) represent the plan number.

Sample Billing Statement:

1 **Group ID:** 12345678

Your Company Name

123 Main Street

Any Town, NY 14444-4444

Account Specialist: 17

Invoice ID: 987654321098

Payment Due Date:

Bill Period From: **To:**

For Enrollment Inquiries, call **For Billing Inquiries, call**

SOC SEC NO	ID NUMBER	NAME	TIER	COV	PLAN	AMOUNT	TOTAL
Subgroup	**0001**	**Active**					
2 **Class**	**0001**	**Community Blue HMO**					
000000000	999999999	Smith John	SNGL	**3**	NCB1Y000	300.00	300.00
	Regular Charges	**Totals By Coverage**		**M**		**300.00**	**300.00**
	Class 0001	**Totals By Coverage** **Regular**		**M**		**300.00**	**300.00**
		Totals By Coverage **Adjustment**		**M**		**300.00**	**300.00**
		Totals By Coverage		**M**		**300.00**	**300.00**

Coverage Catagory	Subscriber Count	Dependent Count	Total Member Count
M - Medical	1	0	1

BlueShield of Northeastern New York

A Division of HealthNow New York Inc.

An Independent Licensee of the BlueCross BlueShield Association

This Is Your Traditional Blue Group Plan Issued by BlueShield of Northeastern New York

This booklet explains the benefits available to you under group plan with BlueShield of Northeastern New York and the group whose name is listed on your identification card. This booklet is issued to the person named on the identification card. This plan will continue unless it is terminated for any of the reasons described in this booklet. The coverage under this plan begins on the effective date shown on the attachment to your identification card.

BlueShield of Northeastern New York
30 Century Hill Drive
Latham, New York 12110

President & CEO

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Section One - Introduction

1. **Under this plan you can receive care as follows.**

   A. **In-Network Benefits.** In-Network Benefits are described in Sections Three through Ten of this Plan. To receive coverage for in-network benefits, the services MUST meet ONE of the requirements below:

      1. The services must be provided by a participating EPO (Exclusive Provider Organization) provider in our local operating area or outside our operating area. A "participating provider" is a hospital, facility, physician, or other provider with an agreement with us regarding payment for in-network covered services under this plan. A "participating provider" is a hospital, facility, physician, or other provider with an agreement with us regarding payment for in-network covered services under this plan.

      2. You receive emergency care covered under the Emergency Care Section Eight of this Plan.

      3. You receive care that meets the requirements outlined within the Continuity of Care paragraph of Section 17 within this plan.

   B. **Out-of-Network Benefits.** You are enrolled within an EPO product. Out-of-network benefits are not covered within this plan unless they are received as emergency care described within Section 8 of this plan.

2. **Your Coverage under the Group Plan.** The organization whose group number is listed on your identification card (referred to as "the group contract holder") has purchased a group contract from us. Under that contract, we will provide the benefits described in this booklet to members of the group, that is, to members of the organization. The benefits provided under the group contract that we describe in this booklet are referred to as "this plan." However, this booklet is not a contract between you and us. You should keep this booklet with your other important papers so that it is available for your future reference.

3. **Words We Use.** Throughout this booklet, BlueShield of Northeastern New York will be referred to as "we," "us," or "our." The words "you," "your," or "yours" refer to you, the member of the group to whom this booklet is issued and whose name appears on the identification card, and to any members of your family who are covered under this plan.

4. **Medical Necessity.** We will not pay for any service, test or treatment, which our medical director determines is not medically necessary for the diagnosis or treatment of your illness, injury or condition. Even if a service is listed as a covered benefit, we will only pay for the service if our medical director determines it is medically necessary and appropriate for your particular case.

   Medically necessary care is care, which, according to our criteria, is:

   A. consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury;

   B. in accordance with standards of good medical practice;

   C. not for your convenience or that of your physician or other provider; and

   D. the most appropriate supply or level of service, which can be safely provided to you.

   Examples of unnecessary care are: when you are admitted to a hospital for care which could have been provided in a doctor's office, or provided without admission to a hospital as a bed patient; when services are performed in a freestanding ambulatory surgery center which could have been performed in a doctor's office; when you are in a hospital for longer than is necessary to treat your condition; when hospitalized, you receive ancillary services not required to diagnose or treat your condition; when the care is provided in a more costly facility or setting than is necessary; when you receive an inappropriate or non-essential

service to diagnose your condition; when the services you receive are more costly than is necessary for the proper treatment of your condition.

In many cases, our medical director has developed guidelines to aid in the determination of whether a service is medically necessary and appropriate in a particular case. You may call us if you have any questions regarding these guidelines. Throughout this plan, "our medical director" shall include the medical director and his or her designees.

5. **Relationship Between Us and Participating Physicians or Providers.** The relationship between us and participating physicians and providers is an independent contractor relationship. Any participating physician or provider is not an employee or agent of ours. We do not control the treatment or other professional activities of any participating physician or provider. Any of our determinations and/or those of our medical director only relate to whether we will make payment for services pursuant to this plan and are not a substitute for the professional judgment of any participating physician or provider.

6. **Our Operating Area.** Throughout this plan, when we refer to "our operating area," we mean the counties of Clinton, Essex, Warren, Washington, Saratoga, Fulton, Montgomery, Schenectady, Rensselaer, Albany, Schoharie, Greene, and Columbia in the State of New York.

7. **Waiting Periods.** No waiting periods for preexisting conditions apply to this plan.

   A. **Preexisting Conditions.** A "preexisting condition" is a condition, (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within six (6) months prior to your enrollment date under this plan. The enrollment date is the date your coverage under this plan became effective, or if the group contract holder requires you to meet a waiting period before you become eligible for coverage through the group, the first day for that waiting period. A future health condition indicated by genetic information is not a preexisting condition, unless the condition itself has actually been diagnosed prior to your coverage under this plan.

8. **Inter-Plan Arrangements for 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 members access healthcare services outside the geographic area we serve, the claim for those services may be processed through one of these Inter-Plan Programs and presented to us for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to members under this contract are described generally below

   Typically, members, when accessing care outside the geographic area we serve, obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, members may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

   A. **Blue Card® Program.** Under the BlueCard® Program, when members access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible to you for fulfilling our contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard® Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

      1. **Liability Calculation Method Per Claim.** The calculation of the member liability on claims for covered healthcare services processed through the BlueCard® Program, if not a flat dollar copayment, will be based on the lower of the participating healthcare

provider's billed covered charges or the negotiated price made available to us by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to us by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

a. an actual price. An actual price is a negotiated payment without any other increases or decreases, or

b. an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

c. an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard® Program requires that the price submitted by a Host Blue to us is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, we would then calculate member liability in accordance with applicable law.

2. **Return of Overpayments.** Under the BlueCard® Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by claim or prospective basis.

Section Two - Who Is Covered

1. **Who Is Covered Under This Plan.** You, the member of the group whose name appears on the identification card, are covered under this plan. If you have a type of coverage other than individual coverage (see paragraph "Types Of Coverage Other Than Individual Coverage" below) the following members of your family may also be covered depending on the type of coverage:

A. your domestic partner, wife, or husband, unless your domestic partnership has terminated, you are divorced, or your marriage has been annulled. Marriages between same sex partners legally performed in other jurisdictions are recognized within this plan;

B. your children who are under the age of 26. Coverage lasts until the end of the month in which the child turns 26 years of age. Your children need not be:

   1. financially dependent upon you for support or claimed as dependents on your tax return;

   2. residents of your household;

   3. enrolled as students; or

   4. unmarried.

   Children-in-law (spouses of children) and grandchildren are not covered.

C. your unmarried children who have not yet reached the end of the month in which they turn 30 years of age, who live, work, or reside in New York State or the service area as set forth in this group plan and who, without regard to financial dependence, are not insured by or eligible for coverage under any employer group Plan as an employee or member of a health plan, and are not covered under Medicare will be considered eligible young adults. These young adults are eligible to elect continuation of coverage until the end of the month in which they turn 30 years of age as an individual policyholder through the primary parent or guardian's employer plan and at the young adult's or primary policyholder's full expense. To elect continuation of coverage, the eligible young adult or primary policyholder must, in writing:

   1. request the continuation within sixty days following the date the coverage would otherwise terminate within this contract.

   2. request the continuation within sixty days after meeting the requirements for young adult status (unmarried children until the end of the month in which they turn 30 years of age, who live, work, or reside in New York State or the service area as set forth in this group plan and who, without regard to financial dependence, are not insured by or eligible for coverage under any employer group Plan as an employee or member of a health plan, whether insured or self-insured, and are not covered under Medicare).

   3. request the continuation coverage during an annual thirty-day open enrollment period, as described in the group plan.

   Coverage of a young adult as described in this paragraph shall consist of coverage which is identical to the coverage provided to the employee or parent. Children of young adults are not eligible for the same continuation rights under this plan, and will not receive benefits under the primary young adult's continuation of coverage. If you are a young adult who exercised your right to purchase an individual policy under the young adult option as described in this paragraph, then your children are not eligible to receive coverage under this group plan.

   Coverage shall terminate on the first of the following to occur:

   1. the date the young adult no longer meets the requirements of an eligible young adult as described above;

   2. the end of the period for which payment has been made, if there is a failure to make payment of a required premium payment;

   3. the date on which the group policy is terminated and not replaced by coverage under another group policy;

4. the date the guardian or parental subscriber loses eligibility for coverage through the employer sponsored plan.

If the young adult exhausts benefits by aging off of this benefit option, the young adult does not have a COBRA/state continuation right

D. Your unmarried dependent child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the mental hygiene law), or physical handicap and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate and who is chiefly dependent upon such policy holder for support and maintenance shall not terminate while your Plan remains in effect and the child remains in such condition, if you submit proof of your child's incapacity within 31 days of the date on which coverage would otherwise terminate.

E. "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.

F. A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order is also covered, subject to the age restrictions outlined above.

2. **Coverage Of Newborns From The Moment Of Birth.** If you have family coverage or child coverage as described below, your newborn child will be covered at birth, if you notify us of the child's birth as required within the "Notification of Change in Your Coverage" paragraph below. In addition, if you have individual or spousal coverage as described below, you may obtain coverage of your newborn child from the moment of birth if you comply with the requirements outlined within the "Notification of Change in Your Coverage" Paragraph below and switch to the appropriate coverage.

   If a child of yours who is covered under this plan gives birth, that newborn grandchild will not be covered.

3. **Adopted Newborns.**

   A. **When We Will Cover Adopted Newborns From The Moment of Birth.** If you have family or child coverage, or switch to family or child coverage in accordance with the "Notification of Change in Your Coverage" paragraph below, we will cover a proposed adoptive newborn from the moment of birth, if the following conditions are met:

      1. you (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the hospital after birth; and

      2. you file a petition pursuant to Section115-c of the New York State Domestic Relations Law within 30 days of the infant's birth.

   B. **When We Will Not Cover Adopted Newborns From The Moment Of Birth.** Notwithstanding the provisions of subparagraph A above, we will not cover adopted newborns from the moment of birth if one of the child's natural parents has coverage available to cover the newborn's initial hospital stay, or if a notice of revocation of the adoption has been filed pursuant to section 115-b of the New York State Domestic Relations Law. We will also not provide coverage to the adopted newborn if one of the natural parents revokes their consent to the adoption. If we pay benefits to cover an adopted newborn and the notice of the revocation of the adoption has been filed, or one of the natural parents revokes their consent, we will be entitled to recover any sums paid by us for care of the adopted newborn.

4. **Domestic partners.** In addition to the list of eligible dependents stated above, your domestic partner may be considered an eligible dependent for purposes of determining who is covered under this plan.

   A. A domestic partnership, for purposes of coverage under this plan, consists of the characteristics set forth below. The partner must be:

      1. 18 years of age or older;
      2. residing with you;
      3. unmarried;
      4. not related by marriage or blood in a way that would bar your marriage to each other; and
      5. financially dependent upon one another.

      The partners must have made a lifetime commitment to each other, and be each other's sole domestic partner. The domestic partnership must have existed for a period of at least six (6) months before we will cover the domestic partner under this plan.

   B. Proving the existence of a domestic partnership. In order to prove the existence of a domestic partnership for purposes of determining eligibility for coverage, all of the following criteria must be met:

      1. **Filing of domestic partner affidavit.** A signed domestic partner affidavit must be filed in an acceptable format with us. In the alternative, if the domestic partners reside in a municipality, which provides for the registration of domestic partnerships, the Certificate of Registration may be submitted instead of the affidavit.
      2. **Proof of cohabitation.** You must provide to us proof of cohabitation. Cohabitation may be proven by presenting documentation, such as driver's licenses or tax returns, which demonstrate that you are living together.
      3. **Proof of economic interdependence.** At least two of the following must be provided to us:

         a. joint bank account;
         b. joint ownership or holding of investments;
         c. joint ownership/lease of a residence;
         d. joint credit cards or charge cards;
         e. joint ownership of a car;
         f. joint obligation on a loan;
         g. status as authorized signatory on the partner's bank account, credit card or charge card;
         h. joint ownership of real estate other than residence;
         i. listing of both partners as tenants on the lease of the shared residence;
         j. shared rental payments of residence (need not be shared 50/50);
         k. listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
         l. common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
         m. shared household budget for purposes of receiving government benefits;
         n. status of one as representative payee for the other's government benefits;
         o. joint ownership of major items of personal property (e.g., appliances, furniture);

p. joint responsibility for child care (e.g., school documents, guardianship);

q. shared child-care expenses. e.g., baby sitting, day care, school bills (need not be shared 50/50);

r. designation as beneficiary under the other's life insurance policy;

s. designation as beneficiary under the other's retirement benefits account;

t. execution of wills naming each other as executor and/or beneficiary;

u. mutual grant of Durable Powers of Attorney;

v. mutual grant of authority to make health care decisions (e.g., health care power of attorney);

w. affidavit by creditor or other individual able to testify to partners' financial interdependence; or

x. other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

The proof of cohabitation and proof of economic interdependence must verify that the cohabitation and economic interdependence have existed for at least the previous six months.

C. **Determination as to eligibility of a domestic partner.** The eligibility of your domestic partner under this plan will be determined by us and your employer. We will not provide coverage under this plan until we receive notice of eligibility of your domestic partner and receive the appropriate premium amount from your group.

D. **Domestic partner's children are included.** The children of your domestic partner are eligible for coverage under this plan if any of the following requirements are met:

1. the dependent children of your domestic partner meet the eligibility requirements that apply to the subscriber's natural or adopted children
2. you legally adopt them;
3. you have filed to adopt them and they are legally dependent upon you during the waiting period prior to adoption becoming final; or
4. you become appointed their legal guardian by court order.

Coverage of the domestic partner's children will terminate:

1. in accordance with the stipulations set forth in this section of the group plan that describe termination of other dependents;
2. upon termination of the group plan; or
3. upon termination of the domestic partnership.

The subscriber must notify us in the event any of the requirements for coverage of the children of the domestic partner cease to be satisfied. We reserve the right to verify that the dependent meets the eligibility requirements of the plan.

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

A. **Two-person Coverage** - If two-person coverage applies, the following members of your family are covered as described above:

1. you, the person to whom this plan is issued;
2. either your domestic partner, or wife, or husband, or your one child.

B. **Child Coverage** - If child coverage applies, the following members of your family are covered as described above:

1. you, the person to whom this Plan is issued;
2. your children.

C. **Family Coverage** - If family coverage applies, the following members of your family are covered as described above:

1. you, the person to whom this plan is issued;
2. your domestic partner, wife, or husband; and
3. your children, as well as the children of your domestic partner.

The names of all persons covered under this plan must have been specified on the application for this plan or provided to us as described in the "Notification of Change in Your Coverage" paragraph immediately 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 type 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. **Notification Of Change In Your Coverage.**

A. **To Add A Spouse, Domestic Partner, Domestic Partner's Child, Or Child.** If you need to add a spouse, domestic partner, domestic partner's child, 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, if you return to us a completed application and requested documents within 30 days of the wedding, birth, or adoption 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 Plan as of the next premium due date after we receive the completed form and requested documentation, so long as the applicable premium is paid. Domestic Partners and the children of your domestic partner will be added on the effective date requested so long as the appropriate premium is paid and the request is made within 30 days of the proposed effective date. The domestic partnership must also have existed for 6 months prior to the requested effective date and this time requirement will need to be substantiated by the proof of cohabitation and proof of economic interdependence requirements. If you do not return the completed form and documentation within 30 days, your domestic partner and the children of your domestic partner will be added to your Plan as of the next premium due date after we receive the completed form and requested documentation, so long as the applicable premium is paid and the domestic partnership duration requirement has been satisfied.

B. **When Coverage Of A Spouse, Domestic Partner, Domestic Partner's Child, or Child Terminates.** If you have other than individual coverage you must notify us of any event that affects your coverage, such as, your divorce, the death of your spouse, the termination of your domestic partnership, and a child marrying or reaching the age at which coverage terminates. You must sign and return to us a form provided by us for that purpose, together with any requested documentation.

C. **Change In Premiums.** If any change in who is covered results in your seeking a different type of coverage at a lower premium (such as a switch from family 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, your change in premium will be effective as of the next premium due date after we receive the information.

Nothing in Subparagraph C is designed to affect the provisions of section 15 governing terminations of coverage. This Subparagraph only involves the effective date of changes in premiums due to terminations of coverage under section 15.

Section Three - Inpatient Care

1. **Care In A Hospital.** We will provide coverage for most of the services customarily furnished by a hospital or other facility, when you are a registered bed patient in a hospital or other facility and receive acute hospital care, as defined below, if all the following conditions are met:.

   A. Your admission to the particular hospital is authorized by us. We may request that you receive inpatient care in a particular hospital, depending upon the services you will require.

   B. While in the hospital, you remain under the care of a physician.

   C. The service is given to you by an employee of the hospital, the hospital regularly bills for the service, and the hospital retains the money collected for the service.

   We will also provide coverage for pre-admission testing performed in hospital facilities prior to scheduled surgery. A patient who uses the out-patient facilities of a hospital shall be entitled to benefits for tests ordered by a physician which are performed as planned preliminary to admission of the patient as an inpatient for surgery in the same hospital provided that:

   D. the tests are necessary for, and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;

   E. you have a reservation for the hospital bed and for the operating room prior to the performance of the tests

   F. surgery actually takes place within seven days of such pre-surgical tests; and

   G. you are physically present at the hospital for the tests.

2. **Acute Hospital Care Defined.** We will only provide coverage for acute hospital care. "Acute hospital care" is care or treatment given or ordered by health care professionals for an illness or injury of a severity that can only be treated in an inpatient Hospital setting.

   The following are not generally considered acute hospital care:

   A. A hospital stay or a portion of a hospital stay in connection with physical check-ups, custodial care, rest cures, sanitarium type care, chemical abuse rehabilitation, or while awaiting placement in a different level of care such as a skilled care facility or home health care, whether or not such placement is available to you.

   B. A hospital stay or a portion of a hospital stay during which, services you received are primarily for diagnostic x-rays, laboratory tests, or other types of diagnostic studies, which could be performed in an outpatient setting; or

   C. Custodial Care. Custodial care means help in transferring, eating, dressing, bathing, toileting, and other such related activities.

   D. A hospital stay or portions of a hospital stay which is primarily for physical rehabilitation except as indicated in the subparagraph “Admissions for Physical Rehabilitation” within this section.

   E. In the event a service is denied as non-acute care, you may have the right to the utilization review procedure in section 16 and the external review procedure in section 16.

3. **Hospital.** "Hospital" means a short-term acute, general hospital, which is primarily engaged in providing to inpatients, by or under the continuous supervision of a physician, diagnostic and therapeutic services for the diagnosis, treatment, and care of injured or sick persons; has organized departments of medicine and major surgery; has a requirement that every patient must be under the care of a physician; provides 24-hour a day nursing services by or under the supervision of registered professional nurses; is duly licensed by the agency responsible for licensing such hospitals; is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, a place for alcoholism, a place for convalescent, custodial, educational, or rehabilitory care, a place for the treatment of mental, nervous, or emotional disorders, or a nursing home or similar institution. Hospital also does not mean health resorts, spas, or infirmaries at schools, colleges, or camps.

4. **Care In A Facility Other Than A Participating Hospital That is Treated As Though It Was Received In A Participating Hospital.** We will provide coverage for acute hospital care in a non-participating hospital and only require the participating hospital member cost share under the following conditions:

   A. Your medical condition is such that, in the judgment of a participating physician and subject to the approval of our medical director, you need to be hospitalized.

   B. In the judgment of a participating physician and subject to the approval of our medical director, you could only receive care for the treatment of your condition in a facility other than a participating hospital. This is care of a more specialized nature than could be given in a participating hospital.

   C. The facility is designated by a participating physician and approved in advance of your care by our medical director.

   Care in the facility will be provided only for as long as you would otherwise have been confined in a participating hospital.

   If care is received as a result of an emergency condition, we will pay for care only as long as our medical director determines that hospitalization was medically necessary and that your medical condition prevented your transfer to a participating hospital.

5. **Inpatient Hospital Services.** We will provide coverage for the following services:

   A. bed, board, and general nursing service in a semi-private room. A semi-private room is a room, which the Hospital considers to be semi-private. If you occupy a private room in a Hospital, you will have to pay the difference between what we pay and the Hospital's charge for the private room;

   B. special diets;

   C. use of operating, recovery, and cystoscopic rooms and equipment;

   D. use of intensive care or special care units and equipment;

   E. diagnostic and therapeutic items for use in the Hospital, such as drugs, medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes, and the administration of such items. However, we will not pay for those items, which are not commercially available for purchase and readily obtainable by the Hospital;

   F. dressings and plaster casts;

   G. professional services, supplies, and use of equipment in connection with:

      1. oxygen;

      2. physiotherapy; and

      3. laboratory and pathological examinations.

   H. use of equipment in connection with:

1. anesthesia;
2. electrocardiograms;
3. electroencephalograms;
4. x-ray examinations;
5. diagnostic imaging;
6. radiation therapy; and
7. chemotherapy.

I. whole blood or blood products, except when participation in a volunteer blood replacement program is available to you. We will provide coverage for autologous blood collection and storage services provided by the hospital and included in their charge for the hospital stay;

J. any additional medical services and supplies which are provided while you are a registered bed patient and which are billed by the hospital; and

K. services of a physician if the physician is employed by the hospital and the charge for the service is billed and retained by the hospital.

6. **Services Not Covered.** We will not pay for the following services:

A. private duty nurses, unless, in the judgment of your physician and our medical director, private duty nurses are medically necessary for your condition.

B. private room, unless in the judgment of your physician and our medical director, a private room is medically necessary for your condition.

C. non-medical items including, but not limited to, television rental or telephone service;

D. whole blood or blood products when participation in a volunteer blood replacement program is available to you. We will, however, provide coverage for autologous blood collection and storage services provided by the hospital and included in their charge for the hospital stay.

E. medications, supplies, and equipment, which you take home from the hospital or other facility.

F. we will not be responsible for any charges incurred after the day we advise you it is no longer medically necessary for you to receive acute inpatient care.

7. **Number Of Days Of Care.** We will provide coverage for care in a hospital or other facility, under the conditions described above, for any day your treating physician and our medical director determine that hospitalization was medically necessary for the care or treatment of your condition, illness, or injury, except for any limitation that may be described below with regard to the number of days of care that will be provided for the treatment of mental, nervous, or emotional disorders or ailments, chemical abuse, physical therapy, or nursing home care. We may designate a particular hospital for your admission, depending upon the care or treatment you need. We will not pay for care received after your treating physician and our medical director determine hospitalization was no longer medically necessary.

8. **Maternity And Newborn Inpatient Care.** We will cover inpatient maternity care in a hospital for the mother and newborn, if covered under this plan, for at least 48 hours following any delivery other than a cesarean section and at least 96 hours following a cesarean section delivery. The services covered 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 cover any additional days of such care which we determine are medically necessary, however in order for newborn claims to be paid for beyond 48 hours for vaginal birth or 96 hours for cesarean birth, the infant must have been added to the health insurance coverage as outlined within the paragraphs “Coverage Of

Newborns From The Moment Of Birth" and "Notification Of Change In Your Coverage" within Section 2 of this contract.

Maternity care shall include the services of a midwife licensed pursuant to Article 140 of the New York Education Law, practicing consistent with a written agreement for a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements of Section 6951 of the Education Law. However, we will not pay for duplicative routine services actually provided by both a licensed midwife and a physician.

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 one home care visit furnished by the type of home care agency described in section seven of this plan. This additional home care visit will not be counted against the visit limit established for home care visits under section 7. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. The home care visit will not be subject to any additional deductible or coinsurance

9. **Inpatient Mastectomy Stays.** We will provide coverage for inpatient hospital care for a hospital stay following a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer, and any physical complications arising from the mastectomy, including lymphedema. The length of stay will be determined by you and your physician.

10. **Inpatient Care for Mental, Nervous,** Or Emotional Disorders or Ailments. If you are confined as an inpatient in a hospital as defined by subdivision ten of Section 1.03 of the New York Mental Hygiene Law, we will provide coverage for an unlimited number of days per person in each plan year for Active Treatment of mental, nervous, or emotional disorders or ailments, if it is medically necessary in the judgment of your treating physician and our Medical Director. Active Treatment means treatment furnished in conjunction with inpatient confinement for mental, nervous, or emotional disorders or ailments that meet such standards as shall be prescribed pursuant to the regulations of the Commissioner of Mental Health.

11. **Admissions For Physical Rehabilitation.** A Hospital stay or a portion of a Hospital stay, which is primarily for physical rehabilitation, is not Acute Hospital Care within the meaning of this plan. However, we will provide coverage for physical 60 days per person per plan year for a hospital stay which is primarily for restorative physical rehabilitation, if it is Medically Necessary in the judgment of your treating physician and our Medical Director.

12. **Care In A Skilled Care Facility.** We will provide coverage for your care in a skilled care facility only if all of the following conditions are met:

    Your treating physician obtains the approval of our medical director before arranging for the care.

    Your treating physician and our medical director determine that your condition, illness, or injury requires that you receive skilled nursing or skilled rehabilitative care on a daily basis and that hospitalization would otherwise be medically necessary.

    "Skilled Care Facility" means a nursing home as defined in Section 2801 of the Public Health Law or a skilled nursing facility as defined in subchapter XVIII of the federal Social Security Act, 42 USC §1395 et seq.

    We will provide coverage for unlimited days of care per person, per plan year. The care in a Skilled Care Facility must be provided in accordance with guidelines on file with our Medical Director. You may contact us if you have any questions regarding these guidelines.

13. **End Of Life Care.** We shall provide coverage for acute care services for you or anyone covered under this Plan, who is diagnosed with advanced cancer with no hope of reversal of primary disease and that has fewer than 60 days to live, as certified by your attending health care practitioner. Coverage shall be provided for services rendered by an acute care facility licensed pursuant to Article 28 of the New York Public Health Law, which specializes

in the treatment of terminally ill patients, if your attending health care practitioner, in consultation with the medical director of the facility, determines that your care would be appropriately provided by the facility. We will provide coverage for an unlimited number of days of care per person, per plan year.

In the event we disagree with the admission, or provision of, or continuation of your care by the facility, for reasons subject to External Appeal, we shall initiate an expedited external appeal in accordance with Section 4914 of the Public Health Law. Until a decision is rendered by the external appeal agent, the admission, or provision of, or continuation of the care by the facility shall not be denied by us and we shall provide coverage and reimburse the facility for services provided subject to the provisions of the law and other limitations otherwise applicable under this plan. In the event we do not initiate an expedited external appeal, we shall reimburse the facility for services provided subject to the provisions of the law and other limitations otherwise applicable under this plan.

14. **Inpatient Detoxification Care for Chemical Dependence.** We will provide coverage for 7 days per person per plan year for acute inpatient hospitalization, when you are a registered bed patient in a hospital for active treatment for detoxification of chemical dependence, if it is Medically Necessary in the judgment of your treating physician and our Medical Director.
15. **Inpatient Rehabilitation Care for Chemical Abuse.** We will provide coverage for 30 days per person per plan year for active treatment in a Hospital or freestanding Affiliated Chemical Abuse Facility for inpatient rehabilitation for the diagnosis and treatment of chemical abuse, if it is Medically Necessary in the judgment of your treating physician and our Medical Director. Inpatient rehabilitation is a 24-hour, live-in program of services for the active treatment of chemical abuse, which provides rehabilitation and treatment for the addictive, loss-of-control phase of alcohol or chemical abuse in a controlled environment.

Section Four - Outpatient Surgery

1. **Conditions For Coverage Of Outpatient Surgery.** We will provide coverage for outpatient surgery in a hospital or in a freestanding ambulatory care center as provided in Paragraph 2 and 3 below if your treating physician and our medical director determine it is medically necessary for such surgery to be performed in the outpatient department of a hospital or in a freestanding ambulatory care center and cannot be performed in a doctor's office, clinic or less intensive setting.
2. **Outpatient Surgery In A Hospital.** If you have outpatient surgery, you are entitled to the same coverage for hospital services provided to you in the outpatient department of a hospital as we would provide if you were an inpatient. As in the case of inpatient surgical care, the services must be medically necessary as determined by your treating physician and our Medical Director.
3. **Outpatient Surgery In A Freestanding Ambulatory Care Center.** If you have outpatient surgery in a freestanding ambulatory care center, you are entitled to the same coverage as we would provide if you were an inpatient in a hospital. As in the case of inpatient surgical care, the services must be medically necessary as determined by your treating physician and our Medical Director.

Section Five - Hospice Care

1. **Type Of Provider.** "Hospice Care" is care provided to terminally ill patients. We will provide coverage for hospice care provided by a hospice organization which has an operating certificate issued by the New York State Department of Health under Article 40 of the Public Health Law. If the hospice care is provided outside of New York State, the Hospice

organization must have an operating certificate issued under standards similar to those used in New York by a state agency in the state where the hospice care is provided.

2. **Eligibility For Benefits.** "Hospice Care" is care provided to terminally ill patients. We will provide coverage for hospice care if both of the following conditions are met:
   A. You must experience an illness for which your treating physician's prognosis for life expectancy is estimated to be 6 months or less.
   B. Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.
3. **Hospice Organizations.** We will provide coverage for hospice care provided by a hospice organization. The hospice services you receive must be authorized by your treating physician and our medical director, and you must remain under the care of the treating physician while receiving hospice services.
4. **Hospice Care Benefits.** We will provide coverage for the following services when provided by hospice:
   A. Bed patient care either in a designated hospice unit or in a regular hospital bed.
   B. Day care services provided by the hospice organization.
   C. Bereavement counseling services provided to the patient's family during illness and after the patient's death.
   D. Home care and outpatient services which are provided by the hospice and for which the Hospice charges you. The services may include the following:
      1. intermittent nursing care by an RN, LPN 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 prescribed by a physician and which are considered approved under the US Pharmacopoeia and/or National Formulary;
      11. Durable Medical Equipment; and
      12. medical care provided by the Hospice physician.
5. **Number Of Visits.** We will provide coverage for an unlimited number of days of care per person, per plan year for hospice. We will also provide coverage for up to five visits for bereavement counseling services to your family, either before or after your death.

Section Six - Medical Services

1. **Medical Services While Hospitalized.** Except as limited by the provisions of paragraph 3 below or the exclusions of section 13, during any hospitalization covered under section 3 or outpatient surgery covered under section 4, we will provide coverage for the services provided by a treating physician or provider.

We will also provide coverage for the same service which a physician can perform when it is performed by a licensed registered professional nurse, but only if all of the following conditions are met:

A. the service is within the lawful scope of practice of a duly licensed registered professional nurse;

B. your illness or condition requires the service and can appropriately be provided by a person with the education and professional skill of a registered professional nurse; and

C. the service is provided in your home or at the offices of a licensed registered professional nurse. The office of the licensed registered professional nurse cannot be part of a physician's office. The practice of the licensed registered professional nurse must be independent of the practice of a physician.

We will not pay for the service if it is provided in a general hospital, nursing home or facility providing health related services as such terms are defined in Section 2801 of the New York State Public Health Law or in a facility, as such term is defined in section 1.03(6) of the New York State Mental Hygiene Law.

2. **Outpatient Care.** Except as limited by the provisions of paragraph 3 below and section 8 or the exclusions of section 13, we will provide coverage for the same services provided to you in the outpatient department of a hospital as we would provide if you were an inpatient. We will provide coverage for pre-admission tests for a hospitalization covered under section 3. The services must be provided by a physician or provider. We will also provide coverage in an urgent care center.

3. **Home Or Office Visits And Other Medical Services.** We will provide coverage for the following services by a physician or provider. Except as provided otherwise, the service must be provided in a physician's or provider's office, or in your home. If a participating physician or provider refers you to a non- participating physician or provider, such referral must be approved in advance by our medical director to qualify for in-network benefits.

   A. Preventive Health Services. We will provide coverage for:

      1. Items and services with an "A" or "B" rating from the United States Preventive Services Task Force;

      2. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations; and

      3. Evidence-informed preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").

      4. Additional preventive services which are not listed above, including: screening for prostate specific antigen, routine annual physical examinations, two routine gynecological examinations annually, one routine vision exam every two years or one vision exam every year for those under the age of 14 diagnosed with refractive error, influenza vaccination, adult immunizations, well child immunizations, well child visits.

      5. The preventive services referenced above shall be covered in full when received from in-network providers. Cost sharing (deductible, copayments, and 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. A list of preventive items and services covered under this paragraph is available on our website at www.bsneny.com or will be mailed upon request. You may call customer service at the number provided on your identification card to request further information.

B. **Diagnosis And Treatment.** Except as otherwise limited by any other provision of this plan, we will provide coverage for the services of a physician or provider for the diagnosis and treatment of your disease, injury, or other condition. This includes surgical procedures, visits, and consultations. This also includes treatment provided in an urgent care center.

C. **Visits In A Hospital.** We will provide coverage for visits to you by a doctor or other medical professional on any day of hospitalization covered under this plan. However, separate payments for visits in connection with surgery or maternity care will not be made, regardless of whether the visits are made by a doctor or other medical professional. The amount of payment for surgery or maternity care includes payment for visits. If one doctor or other medical professional is treating for a separate and distinct condition, we will pay for one visit per day by the other doctor or other medical professional.

   If you are admitted to a hospital not knowing whether surgery will be performed, we will provide coverage for visits to you prior to the determination that surgery will be performed. We will not provide coverage for more than one visit per day, regardless of whether such visits are by a doctor or other medical professional.

   Payment will be made for only one visit per day unless you are entitled to payment for care described below.;

D. **Critical Care In A Hospital.** We will only provide coverage for care by a doctor while you are a registered bed patient in a hospital during a period of illness which is so serious or critical that it requires constant bedside attendance by the doctor. We will determine if such constant bedside attendance was necessary. We will not provide coverage for a regular visit on that day. Separate payments for all services related to your constant bedside care will not be made, because the amount of the payment for constant bedside care includes all related services.

E. **Consultations In A Hospital.** We will provide coverage for a consultation requested by your doctor if:

   1. The consultation was required by your illness.
   2. The consultation took place while you were a registered bed patient in a hospital.
   3. The consultant did not provide care or treatment for you after he or she consulted with your doctor.
   4. The consultant entered a written report in your hospital record.
   5. The consultant meets the definition of a doctor or other medical professional.

   Coverage will be provided for no more than two consultations during each hospital admission. The consultations must be rendered by two different doctors. However, if because of the serious or critical nature of your illness, additional consultations are necessary, we will provide coverage for as many additional consultations as we determine were necessary for your care. We will not provide coverage for a surgical consultation if you receive payment for a second surgical opinion with respect to the same proposed surgical procedure.

F. **Outpatient Or Office Rehabilitative Therapy.** We will provide coverage for up to an aggregate of 60 visits for physical, occupational, and speech therapy per person, per plan year when a treating physician and our medical director determine that it is medically necessary.

G. **Outpatient Or Office Cardiac Rehabilitation Program.** We will provide coverage for a program of cardiac rehabilitation consisting of cardiac monitoring and the presence of a professional staff, if approved in advance by our medical director. We will pay for 24 visits per plan year provided in a 12 week period following an acute episode of a heart condition.

H. **Injectable Medications.** We will only provide coverage for injectable medications which must be administered by a physician or provider in the physician's office for preventive or therapeutic purposes.

I. **Assistance At Surgery In A Hospital.** We will provide coverage for the services of a second physician, physician's assistant or nurse practitioner assisting a physician who performs the operation if:

1. The operation takes place in a hospital where there is no house staff.
2. The operation takes place in a hospital where there is no hospital resident in the specialty involved, certified or authorized, to assist at surgery.
3. The complexity of the procedure is such that only a doctor could assist.
4. The assistance is in connection with a surgical operation or procedure which is covered under this plan.

J. **Anesthesia.** We will provide coverage for the administration of anesthesia in connection with surgery or maternity care covered under this plan if the nature of the procedure requires anesthesia. If the doctor who administers the anesthesia also performs the surgery, or gives the maternity care, or assists the doctor who performs the surgery, or gives the maternity care, no payment will be made for anesthesia. We will not provide coverage for charges related to local anesthesia, unless this local anesthesia is medically necessary. We will provide coverage for anesthesia related to dental care or treatment in connection with accidental injury to sound natural teeth within 12 months of the accident and for dental care or treatment necessary due to congenital disease or anomaly.

K. **Allergy Testing And Treatment.** We will provide coverage for tests which are Medically Necessary to determine the nature of allergies and desensitization treatments to alleviate allergies, including test or treatment materials.

L. **Outpatient and Office Based Treatment of Mental, Nervous, or Emotional Disorders or Ailments.** We will provide coverage for outpatient visits in connection with the diagnosis and treatment of mental, nervous, or emotional disorders or ailments provided to you on an outpatient basis in your treating Physician's or Provider's office, by a facility issued an operating certificate by the New York State Commissioner of Mental Hygiene pursuant to Article 31 of the New York State Mental Hygiene Law, in a facility operated by the New York State Department of Mental Hygiene, or by a psychiatrist or psychologist licensed to practice in this state or a professional corporation or university faculty practice corporation thereof. We will provide coverage for an unlimited number of visits per person per plan year. In addition, we will also provide coverage for these same services when they are provided by a social worker who is certified under Article 154 of the New York Education Law and who has either:

1. three years post degree experience in psychotherapy, which for the purpose of this contract means the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behaviors which are intellectually, socially or emotionally maladaptive, under supervision, satisfactory to the state board for social work in a facility licensed or incorporated by an appropriate governmental department providing services for diagnosis or treatment of mental, nervous, or emotional disorders or ailments; or
2. three years post degree experience in psychotherapy under supervision, satisfactory to the state board for social work, of a psychiatrist, a certified registered psychologist or a social worker qualified for reimbursement.

The state board for social work in Albany maintains a list of all the certified social workers who meet these qualifications. The social worker must bill you for the services provided and the services must be within the lawful scope of the social worker's

practice. The services provided by these social workers will be counted towards any applicable visit limitation for outpatient care of mental, nervous, or emotional conditions.

In addition to the services mentioned above, we will also pay for treatment in an Intensive Outpatient Program or Partial Hospitalization Program when the services are rendered by providers and facilities that meet the same requirements previously outlined and as the services are described below:

3. Intensive outpatient programs provide care that does not require an inpatient stay. This is a day or evening treatment program which includes counseling or therapeutic services. Services are planned and regularly scheduled in a facility or outpatient provider group. Intensive outpatient program visits will be included in the calculation of any outpatient and office based mental, nervous, or emotional disorder or ailment visitation limits that may exist.
4. Partial hospitalization programs provide care that does not require an inpatient stay. This is a day or evening treatment program which includes medical oversight, nursing counseling or therapeutic services. Services are planned and regularly scheduled in a mental health facility or hospital. One inpatient mental health day may be used for two partial hospitalization treatment visits.

M. **Outpatient Treatment Of Chemical Abuse And Chemical Dependence.** We will provide coverage for outpatient visits in a facility described below for the diagnosis and treatment of chemical dependence when such visits are medically necessary. We will not pay for visits which consist primarily of participation in programs of a social, recreational, or companionship nature. We will not pay for visits compelled by court order or other disciplinary procedures, if they are not otherwise medically necessary. The services must be provided by an employee of the facility. We will not make any payments to an individual who provides any of the covered services; nor will we make payments if the facility turns the payments over to a person who provided the service.

1. **Chemical Abuse And Chemical Dependence Defined.** Chemical abuse shall mean and include alcohol and substance abuse. Chemical dependence shall mean and include alcoholism and substance dependence.
2. **Number Of Visits.** We will provide coverage for 60 outpatient visits per person per year for the treatment of alcoholism and substance dependence. Up to 20 of these visits may be used for family therapy by a covered member under this plan when the individual identifies himself/herself as a family member of a person suffering from the disease of alcoholism, substance abuse, or chemical dependency. This family therapy is available to members covered under this plan, even if the family member that is identified as the person suffering from the disease of alcoholism, substance abuse, or chemical dependency is not covered under this plan. A member covered under this plan may use a family visit for themselves and include as part of that visit other family members that may or may not be covered under this plan. Family therapy consists of the visits described above which are intended to help affected family members better understand the illness, and to help them play a meaningful role in recovery. Our payment for a family therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.
3. **Facilities Where We Will Pay For Treatment.** Coverage is limited to treatment facilities which are certified by the Office of Alcoholism and Substance Abuse Services or licensed by such office as outpatient clinics or medically supervised ambulatory substance abuse programs. When treatment is received outside of New York State, care must be received in an outpatient clinic or medically supervised ambulatory substance abuse program accredited by the Joint Commission on Accreditation of Hospitals as Alcoholism or Chemical Dependence Treatment Programs. We will make payments even if the facility is owned, operated, or maintained by a state government or any local government, even though this plan

otherwise excludes coverage in government Hospitals. However, the facility must be certified as described above and we will not make payments if the facility would not have charged you if you were not covered by insurance.

In addition to the services mentioned above, we will also pay for treatment in an Intensive Outpatient Program or Partial Hospitalization Program when the services are rendered by providers and facilities that meet the same requirements previously outlined and as the services are described below:

4. Intensive outpatient programs provide care that does not require an inpatient stay. This is a day or evening treatment program which includes counseling or therapeutic services. Services are planned and regularly scheduled in a facility or outpatient provider group. Intensive outpatient program visits will be included in the calculation of any outpatient chemical abuse and chemical dependence visitation limits that may exist.

5. Partial hospitalization programs provide care that does not require an inpatient stay. This is a day or evening treatment program which includes medical oversight, nursing counseling or therapeutic services. Services are planned and regularly scheduled in a mental health facility or hospital. One inpatient rehabilitation day for chemical abuse may be used for two partial hospitalization treatment visits.

N. **Second Surgical Opinion.** We will provide coverage for a second surgical opinion under the following conditions:

1. Your treating physician recommends that surgery be performed.
2. The second surgical opinion is rendered by a physician who is a board certified specialist and who, by reason of his specialty, is an appropriate physician to consider the proposed surgical procedure.
3. The second surgical opinion is rendered with respect to an inpatient surgical procedure of a non-emergency nature for which benefits would be provided under this plan if such surgery was performed.
4. The board certified specialist who renders the second surgical opinion does not also perform the surgery for which the second surgical opinion was obtained.

O. **Second Medical Opinions for Cancer Diagnosis.** We will provide coverage for an office visit and related diagnostic tests 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 physician as having some form of cancer. A negative diagnosis of cancer occurs when your physician performs a cancer screening exam on you and finds that you do not have cancer. We will provide coverage for a second medical opinion concerning any recommendation of a course of treatment for cancer. The specialist rendering the second medical opinion must be an appropriate physician including, but not limited to, a specialist affiliated with a specialty care center for the treatment of cancer. If you receive an approved written referral from your physician to a non-participating specialist, you will be required to pay the same amount you would have paid if you received care from a participating specialist.

P. **Surgery For Breast Reconstruction.** We will provide coverage for surgical services for all stages of reconstructive surgery on a breast on which a mastectomy has been performed. We will cover reconstructive surgical procedures on the other breast to produce a symmetrical appearance. We will also cover physical complications of the mastectomy, including lymphedema. Coverage will be provided for all such services rendered in the manner determined appropriate by you and your treating physician or provider.

Q. **Obstetrical Services.** We will provide coverage for a full range of services with respect to pregnancy. The services include prenatal visits, postnatal visits, abortion, and all of the other services set forth above.

We will also provide coverage for the following services from a qualified physician or provider:

1. Care related to a pregnancy.
2. Up to two (2) annual examinations for primary and preventive obstetric and gynecologic care.
3. Obstetric and gynecological care required as a result of such annual examinations or as a result of an acute gynecological condition.
4. You do not need prior authorization from us or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a provider who specializes in obstetrics or gynecology. The provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. You may call customer service at the number provided on your identification card to request a list of providers who specialize in obstetrics or gynecology.

R. **Radiation Therapy,** Chemotherapy and Hemodialysis. We will provide coverage for radiation therapy and services, medications related to non-experimental cancer chemotherapy, cancer hormone therapy and hemodialysis in an outpatient department of a hospital or doctor's office. The services must be related to and necessary for the treatment or diagnosis of the patient's illness or injury and they must have been ordered by a physician.

S. **Chiropractic Care.** Chiropractic care is a covered service when it is:

1. Determined to be medically necessary.
2. Rendered by a provider within the scope of his or her licensure.

For the purposes of this subparagraph, chiropractic care means 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 in or of the vertebral column.

T. **Mammography Screenings.** We will provide coverage for the hospital and medical costs related to mammography screenings for occult breast cancer performed in a Hospital or physician's office subject to the following aggregate limitations:

1. Women At Risk. We will provide coverage for a mammogram for women of any age who have a prior history of breast cancer or whose first degree relative has a prior history of breast cancer, if the mammogram is recommended by a physician.
2. Women 35 Through 39 Years Of Age. We will provide coverage for one baseline mammogram for women 35 through 39 years of age.
3. Women 40 Years Of Age And Older. We will provide coverage for one mammogram in each plan year for women 40 years of age and older with or without the recommendation of a physician.

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.

U. **Cervical Cytology Screening (Pap Smears).** We will provide coverage for one cervical cytology screening for cervical cancer and its precursor states each plan year for

women 18 years of age or older. The screening may be provided in the outpatient department of a hospital, or in a physician's office. Cervical cytology screening shall include 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.

V. **Diagnostic Screening For Prostate Cancer.** We will provide coverage for the hospital or medical costs related to diagnostic screening for prostate cancer upon the prescription of a health care provider legally authorized to prescribe under Title Eight of the Education Law, subject to the following conditions:

1. Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer.
2. An annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age fifty and over who are asymptomatic and for men age forty and over with a family history of prostate cancer or other prostate cancer risk factors.

W. **Electrocardiographic Examinations (ECG).** We will provide coverage for electrocardiogram examinations (ECG) rendered in the outpatient department of a hospital or a physician's office, if medically necessary for the diagnosis and treatment of your condition.

X. **Electroencephalographic Examinations (EEG).** We will provide coverage for electroencephalographic examinations (EEG) rendered in the outpatient department of a hospital or a physician's office, if medically necessary for the diagnosis and treatment of your condition.

Y. **Bone Mineral Density Measurement And Testing.** We will provide coverage for the following Bone Mineral Density (BMD) Studies consistent with the standards of the Medicare Program and the criteria of the National Institute of Health (NIH): Single Photon Absorptiometry, Single Energy X-ray Absorptiometry (SEXA), Dual Energy X-ray Absorptiometry (DEXA), Bone Biopsy, Photodensitometry, Ultrasound Bone Density, Computerized Tomography BMD, and other tests that are consistent with Medicare and NIH standards.

Individuals meeting one or more of the following criteria are eligible to receive coverage for the bone measurement testing procedures:

1. previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
2. with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
3. on a prescribed drug regimen posing a significant risk of osteoporosis; or
4. with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
5. with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

The types of tests and the criteria listed above for eligible individuals is based on the current Medicare program requirements. These standards may change from time to time. Please contact us for the current testing and eligibility criteria.

Z. **Radiology And Other Imagery.** We will provide coverage for diagnostic x-rays, other imagery, and radiation or radioactive material.

We will only provide coverage for radiology and other imagery procedure if the procedure you receive is the most appropriate for the diagnosis or treatment of your condition. For example, we will not provide coverage for Magnetic Resonance Imaging

(MRI) when an x-ray or clinical examination could have been used to diagnose your condition. The fact that your doctor ordered the particular procedure does not mean that the procedure qualifies for payment under this plan.

We will not provide coverage for routine Hospital admission film or dental pathology (except we will pay for x-rays in connection with accidental injury to sound natural teeth if rendered within 12 months of the accident and as required for the treatment of congenital defect or anomaly).

AA. **Outpatient Laboratory Tests.** We will provide coverage for diagnostic laboratory and routine clinical tests when rendered in a participating laboratory site, which may include an outpatient department of a hospital or facility, a doctor's office, or an independent licensed laboratory, when ordered by your doctor.

BB. **Surgery.** Surgery includes closed reduction of fractures, dislocation of bones, endoscopic procedures, and any incision or puncture of the skin or other tissue except for inoculation, vaccination, collection of blood, drug administration or injection. Coverage for surgery is subject to the following limitations:

1. When multiple surgical procedures are performed at the same operative session and through different incisions, we will provide coverage for the major procedure and, in addition, we will cover one-half of the payment otherwise payable for the lesser procedure.
2. When multiple surgical procedures are performed during the same operative session and through the same incision, we will cover the major procedure.
3. When a surgical procedure is performed in two or more steps or stages, the total payment for the combination of steps or stages which make up the entire procedure will be limited to the amount which we would cover for such surgical procedure if it were not performed in steps or stages.

4. **Durable Medical Equipment.** We will provide coverage for durable medical equipment which has been approved in advance by our medical director for as long as our medical director determines that it is medically necessary. We will determine whether the item should be purchased or rented.

Durable medical equipment means equipment that:

A. is intended for repeated use (the type of item that could normally be rented);

B. is not designed for a specific individual's use;

C. is primarily and customarily used for a medical purpose as opposed to a comfort purpose;

D. is not useful to a person in the absence of illness or injury; and

E. is used at your home.

The items we will provide coverage for include oxygen and oxygen equipment, a non-motor driven wheelchair or hospital bed, and crutches. Repair, replacement, fitting and adjustments are covered, when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered. Items we will not provide coverage for include, but are not limited to, items not medical in nature, disposable supplies, exercise and hygiene equipment, sauna baths, air conditioners, humidifiers and dehumidifiers, wigs, hair prosthesis, experimental or research equipment, and electronic communication devices. Also, we will not provide coverage for deluxe equipment (such as a motor-driven wheelchair) when it is not medically necessary. Notwithstanding the provisions of this paragraph, we may pay for experimental or research equipment if approved by an external appeal agent as described in section 16.

5. **Post-mastectomy Prosthetics.** We will provide coverage for post-mastectomy prosthetics which are directly related to the treatment of your condition.

6. **Prosthetic and orthotic appliances.** Prosthetic and orthotic appliances which have been approved in advance by a physician and our medical director will be covered for as long as our medical director determines that they are medically necessary.

   The appliance must be a prosthetic or orthotic device that is generally used for a medical purpose, as opposed to a comfort purpose. Benefits are provided only for the basic prosthetic or orthotic appliances and any medically necessary special feature prescribed by your physician and approved by us.

   The items we will provide coverage for include artificial joints necessary for joint repair and reconstructive surgery; breasts, internal and external, for post-mastectomy reconstruction; artificial eyes; artificial limbs replacing all or part of absent extremities; and, post-laryngectomy care.

   Items we will not pay for include, but are not limited to, arch supports; corrective shoes; orthotics used solely for sports; eyeglasses or contact lenses; hearing aids; wigs; hair prostheses; experimental or research appliances or devices; electronic communication devices; and dental prosthetics, including crowns, caps, bridges, dentures, and braces. However, we will provide coverage for dental prosthetics required as a result of accidental injury to sound natural teeth if provided within 12 months of the accident and dental prosthetics or treatment necessary due to congenital disease or anomaly.

   Notwithstanding the provisions of this paragraph, we may provide coverage for experimental or research appliances or devices if approved by an external appeal agent.

   We maintain a complete list of the external prosthetic and orthotic appliances we will cover and you may contact us if you have any questions concerning whether a particular appliance will be covered.

   We will determine whether the item should be purchased or rented. Repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear or by body growth or change. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered.

7. **Health Education and Wellness Programs.** We will provide coverage for certain health education and wellness programs designed to provide health education and to encourage you to do things including, but not limited to, eating properly and stopping smoking. All such health education and wellness programs must be received through providers designated by us. The topics, time, and frequency of the programs will be determined by us and our designated providers. The annual in-network deductible and coinsurance set forth in this contract shall not apply to services obtained through participating Health Education and Wellness Programs.

Section Seven - Home Care

1. We will provide coverage for visits by a home health care agency in your home if your treating physician and our medical director determine that the visit is medically necessary. The visit may include the following:

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

   B. Part-time or intermittent home health aide services which consist primarily of caring for you.

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

D. Medical supplies, drugs and medication prescribed by a physician, but only if we would have covered these items if you were in a hospital or confined in a skilled care facility.

E. Laboratory services provided by or on behalf of the home health agency.

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

   A. If you did not receive home care visits, you would have to be hospitalized and receive acute hospital care or care in a skilled care facility and receive skilled nursing or skilled rehabilitative care. In other words, the home care visits are a substitution for acute hospital or skilled care facility.

   B. A plan for your home care is established and approved in writing by a physician. Visits in your home will be provided in accordance with guidelines on file with our medical director. You may contact us if you have any questions regarding these guidelines.

3. **Home Care Visit.** 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 described in the paragraph entitled "Maternity And Newborn Inpatient Care " in section 3, we will provide coverage of a home care visit furnished by the type of home care agency described under this section. 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.

4. **Number Of Home Care Visits.** We will provide coverage for home care visits and the other services listed above only for 365 visits per person, per plan year. Each visit by a member of a home care team is counted as one home care visit. Four hours of home health aide service are counted as one home care visit.

5. **Infusion Therapy.** We will provide coverage for infusion therapy provided to you in an outpatient setting or in your home if the conditions for home care are satisfied. Infusion therapy is the administration of drugs or nutrients using specialized delivery systems which otherwise would have required you to be hospitalized. For example, drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs or nutrients taken by mouth or self-injected into the muscles are not considered infusion therapy. The services must be ordered by a physician and provided by an agency licensed or certified to provide such services. Our coverage includes the cost of the drugs, supplies, and nursing services necessary to provide the Infusion Therapy.

Section Eight - Emergency Care

1. **Emergency Room Care.** We will provide coverage for care rendered in the emergency room of a hospital in case of an emergency condition.

2. **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:

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

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

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

   D. Serious disfigurement of such person.

3. **Emergency Services.** A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the

emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

4. **Coverage.** Emergency Services are not subject to prior authorization requirements.

5. **Cost Sharing.** Regardless of whether or not the emergency care is rendered by a participating or non-participating facility or provider, after the deductible you will be responsible for the in-network coinsurance amount when these services are provided as a result of an Emergency Condition as defined above.

   IF YOU OBTAIN CARE IN AN EMERGENCY ROOM AND YOUR CONDITION DID NOT MEET THE DEFINITION OF "EMERGENCY CONDITION" DESCRIBED ABOVE, WE WILL MAKE NO PAYMENT FOR YOUR EMERGENCY ROOM CARE.

6. **Notifying Us.** You are not required to notify us prior to receiving treatment for any condition which qualifies as an "emergency condition" as described above. However, you or a member of your family should notify a participating physician within 48 hours after the emergency occurred so that your care can be coordinated. If it is not reasonably possible to give notice within 48 hours, notice should be given as soon as it is reasonably possible.

7. **Limitation On Coverage For Care For An Emergency Condition In A Hospital.** We will provide coverage for care in a non-participating hospital at the in-network member responsibility for only as long as our medical director determines that hospitalization was medically necessary and that your medical condition prevented your transfer to a participating hospital. Any care received from a non-participating provider after our Medical Director has determined that your medical condition no longer prevented your transfer to a participating hospital will be treated as care received from a non-participating provider.

8. **Pre-hospital emergency medical services.** If you experience an emergency condition and the need for pre-hospital emergency services and/or non-airborne transportation to a hospital arises, we will provide coverage for those services. We will provide coverage for airborne transportation if medically necessary to a hospital from the scene of the accident or illness. Our payment will be made if the following conditions are met:

   A. Services must be provided by an ambulance service issued a certificate to operate under Section 3005 of the Public Health Law.

   B. Pre-hospital evaluation and treatment services must be for an emergency condition.

   C. Coverage for non-airborne emergency transportation must be for an emergency condition.

   D. It was necessary that you were moved by ambulance to the hospital. Transfer of patients between hospitals or other health care facilities by an ambulance service is not a covered benefit unless this method of transportation was medically necessary.

   E. Regardless of whether or not the pre-hospital emergency services are rendered by a participating or non-participating facility or provider, after the deductible you will be responsible for the in-network coinsurance amount when these services are provided as a result of an Emergency Condition as defined above.

   F. Services for stretcher vans, wheelchair vans or any other form of non-emergency transportation is not a covered benefit.

Section Nine - Treatment of Diabetes And Diabetes Self-management Education

Insulin, Glucagon And Prescription Oral Agents For Controlling Blood Sugar. We will provide coverage for insulin, glucagon, and prescription oral agents for controlling blood sugar ("diabetic drugs") when prescribed for your use outside of a hospital, nursing home, doctor’s office, or other institution. The prescription order must be issued by a physician or provider who

is authorized to prescribe under Title Eight of the New York State Education Law. The physician or other provider must be legally authorized to issue the prescription order. The prescription order must be filled by a licensed pharmacist in a retail pharmacy licensed by the state.

1. **Payment.** The amount of our payment under this section depends on whether the prescription is filled at a participating diabetic drug provider or at a non-participating diabetic drug provider.

   A. **Participating Diabetic Drug Provider.** A participating diabetic drug provider is a pharmacy which has entered into an agreement to provide covered diabetic drug benefits to the persons covered by this plan and has an agreement for the payment of covered diabetic drugs. A pharmacy may be a participating diabetic drug provider even though it is not a participating pharmacy under a drug rider under which you are covered. Call us for a list of participating diabetic drug providers as this list may change from time to time.

   B. **Non-Participating Diabetic Drug Provider Within Our Operating Area.** A non-participating diabetic drug provider is a pharmacy which has not entered into an agreement for the payment of covered diabetic drugs under this plan. We will not make any payment for diabetic drugs or refills filled at a pharmacy which is not a participating diabetic drug provider within our operating area.

   C. **Non-Participating Diabetic Drug Provider Outside Our Operating Area.** If your prescription is filled by a pharmacy which is not a participating diabetic drug provider outside of our operating area, you must pay the pharmacy and then you must submit a claim form and receipt to us which verifies that the prescription or refill was filled. We will then pay you 100 percent of the reasonable charge for the diabetic drug or refill minus the copayment. The reasonable charge is a charge which is not greater than the average amount we pay participating diabetic drug providers for that diabetic drug. If the pharmacy's charge is greater than the reasonable charge, we will not pay any part of the excess amount.

2. **Diabetic Equipment And Supplies.** We will provide coverage for the following equipment and supplies for the treatment of diabetes when they are prescribed by a physician or provider. The prescribing physician or provider must be authorized to prescribe under Title Eight of the New York State Education Law and we must determine that they are medically necessary:

   A. blood glucose monitors;

   B. blood glucose monitor for the visually impaired;

   C. data management systems;

   D. non-prescription oral agents for controlling blood sugar;

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

   F. injection aids;

   G. cartridges for the visually impaired;

   H. insulin pumps and pump accessories;

   I. insulin infusion devices; and

   J. syringes and needles used in diabetic management.

   We will also provide coverage for such additional diabetic equipment and supplies as the New York Commissioner of Health shall designate by rule or regulation as medically necessary and appropriate for the treatment of diabetes. Repair, replacement, and adjustments are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered.

4. **Diabetes Self-Management Education.** Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of the diabetic condition including information on proper diets. We will provide coverage for diabetes self-management education if we determine it is medically necessary for you to receive that education:

   A. upon diagnosis as a diabetic;

   B. upon a physician's diagnosis of a significant change in your conditions or symptoms requiring a change in self-management; or

   C. when we determine that re-education or refresher education is necessary.

   We will cover such education provided during an office visit by a physician or certified nurse practitioner or their staff. However, in the case of an office visit, no separate payment will be provided for the education because our payment for the office visit will constitute payment for the entire office visit, including the education. We will also cover such education when it is provided by a certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician upon referral of a physician or nurse practitioner, but only when it is rendered in a group setting, when practicable. Please contact us if you need assistance arranging for group education.

   In addition, we will provide coverage for diabetes self-management education in your home if we determine it is medically necessary for you to receive that education at home. Diabetes self-management education in your home must be provided by a certified diabetes nurse educator, certified nutritionist, certified dietician, or registered dietician.

5. **Health Education And Wellness Programs.** Health education and wellness programs will include diabetes self-management education, which is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. Such programs must be received through providers designated by us. The annual in-network deductible and coinsurance set forth in this contract shall not apply to diabetes self-management programs received through participating Health Education and Wellness Programs.

Section Ten - Infertility Treatments

We will provide coverage for services provided as part of hospital, surgical and medical care that would correct malformation, disease or dysfunction resulting in infertility. We will also provide coverage for individuals covered under this plan whose ages range from twenty-one through forty-four years of age for diagnostic tests and procedures, surgical, or medical procedures which are necessary to determine infertility or correct malformation, disease, or dysfunction resulting in infertility including: hysterosalpingogram; hysteroscopy; endometrial biopsy; laparoscopy; sono-hysterogram; post coital tests; testis biopsy; semen analysis; blood tests; ultrasound; artificial insemination; and prescription drugs if prescription drug coverage is otherwise included within this plan.

The diagnosis and treatment of infertility must be prescribed by a physician in a plan of care.

Section Eleven - In-Network Payments

1. **Services For Which We Will Not Make Payment.** We will not make payment for services billed separately that are part of another covered service. In determining coverage for multiple services billed, we will use national standards and local guidelines. We will also not make payment if the service billed is not properly represented in supporting documentation, such as your medical records. We will not pay for services of a physician or other provider if the physician is employed by the hospital, or the charges for the services are billed and retained by the hospital.

2. **Deductible.** Preventive services, prescription drugs, and health education and wellness programs do not require the deductible. With exception to these services, we will not make any payment for covered services under this plan until the deductible has been satisfied. Individual contracts will be subjected to a $1,500 per plan year deductible. If you are enrolled in a coverage type other than individual, then we will not make any payments until covered members have collectively satisfied a per plan year deductible amount of $3,000. After this deductible has been satisfied, most services will require coinsurance.

3. **Coinsurance.** You must pay 0% coinsurance for in-network medical services, with the exception of preventive services and health education and wellness programs. Preventive services and health education and wellness programs do not require coinsurance.

4. **Maximum Payment by You.** Once a member enrolled within individual coverage has paid a total of $2,500 in deductible, coinsurance, and copayments within a plan year for covered benefits, no further coinsurance or copayments will be required for covered services throughout the remainder of the plan year. If you are enrolled within a plan type other than individual, then once all covered members have collectively paid a total of $5,000 in deductible, coinsurance, and copayments within a plan year for covered benefits, no further coinsurance or copayments will be required for covered services throughout the remainder of the plan year for any covered members. Any amounts you are obligated to pay in excess of any limitation on benefits will not be included when calculating the maximum payment.

Section Twelve - Out-Of-Network Payments

1. You are enrolled within an EPO product, so that out-of-network benefits are not covered unless they are specifically identified otherwise within sections 3 through 10 of this plan. Examples of services that will be covered even when they are received from non-participating providers include:
   A. Inpatient care as outlined within the fourth paragraph of section 3.
   B. Emergency Room care as outlined within section 8.
   C. Ambulance and air ambulance transportation as outlined within section 8.
   D. Urgent Care

2. **Services For Which We Will Not Make Payment.** In addition to the services listed immediately above, we will not make payment for services billed separately that are part of another covered service. In determining coverage for multiple services billed, we will use national standards and local guidelines. We will also not make payment if the service billed is not properly represented in supporting documentation, such as your medical records. We will not pay for services of a physician or other provider if the physician is employed by the hospital, or the charges for the services are billed and retained by the hospital.

Section Thirteen - Exclusions

In addition to certain exclusions and limitations already described in this plan, we will not pay under this Plan when any of the following apply to you:

1. **Admission To A Hospital Before You Become Covered Under This Plan.** If you are admitted to a hospital as a registered bed patient before the date you become covered under this plan, we will only pay for covered services rendered during that stay after the effective date of coverage and only to the extent those services are not covered under any other health insurance policy.

2. **Government Hospital.** Except as otherwise required by State or Federal law, we will not pay for hospital care or services rendered in any hospital or other institution which is owned, operated, or maintained by the federal government, a state government, or any local government, unless the hospital is a participating hospital. However, we will provide coverage for care covered under this plan in such a hospital if, because of an emergency

condition, you are taken to one of these hospitals because it is close to the place where you were injured or became ill.

The conditions for coverage of emergency care described in this plan must be satisfied. In this type of emergency situation, we will continue to make payments only for as long as our medical director determines that hospitalization for the emergency care is medically necessary and that your medical condition prevents your transfer to a participating hospital.

3. **Mandatory No-Fault Automobile Insurance.** We will not pay for any service or care that is eligible for coverage by mandatory no-fault automobile insurance until you have used up all the benefits under the mandatory no-fault policy. If your claim for no-fault benefits is denied, you must file for an arbitration hearing, if we request you to do so. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under any available mandatory no-fault policy. This plan will provide coverage when you have exceeded the maximum benefits for mandatory no-fault.

   Should you be denied benefits under the no-fault policy because it has a deductible, we will provide coverage for services in this plan.

4. **Workers' Compensation.** We will not pay for any care for any injury, condition, or disease if you have received benefits under Workers' Compensation Law or similar legislation.

5. **Free Care.** We will not pay for any care if the care is furnished to you without charge or would normally be furnished to you without charge. This exclusion will also apply if the care would have been furnished to you without charge if you were not covered under this plan or under any other insurance. We will not pay for services performed by a member of your immediate family.

6. **Government Programs.** We will reduce our payments under this plan by the amount you are eligible to receive for the same services under Medicare or under any other federal, state, or local government program, except that we will pay for services covered under this plan even though you are eligible for Medicaid. If you are eligible for Medicare benefits, you will receive the benefits of this plan reduced by any benefits available under Medicare. This applies even if you fail to enroll in Medicare or do not claim the benefits available under Medicare. You must enroll for coverage under both Part A and Part B of Medicare and must inform us of your eligibility for Medicare. However, we will not reduce our payments under this plan if the provisions of Paragraphs A, B or C below apply to you.

   A. **Eligibility For Medicare By Reason Of Age.** If you are eligible for coverage under Medicare by reason of age, our payments under this plan will not be reduced if the person to whom this Plan is issued is an active employee of the remittance group which arranged for coverage under this plan. Also, the benefits of an active employee's spouse will not be reduced if the spouse is eligible for coverage under Medicare by reason of age. The employer which arranged for coverage under this plan must be an employer which is subject to the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as amended. This special provision applies only to persons at least age 65. This special provision does not apply if the person to whom this plan is issued is a retired employee of the group which arranged for coverage under this plan.

   B. **Eligibility For Medicare By Reason Of Disability.** If you are eligible for coverage under Medicare by reason of disability, our payments under this plan will not be reduced if the person to whom this plan is issued is an active employee of the remittance group which arranged for coverage under this plan. This special provision applies to the person to whom this plan is issued if disabled and eligible for Medicare, and to that person's spouse if disabled and eligible for Medicare, and to any other covered dependent of that person if disabled and eligible for Medicare. The remittance group which arranged for coverage under this plan must be a "Large Group Health Plan" as defined in the Omnibus Budget Reconciliation Act of 1986 (OBRA). Generally, a Large Group Health Plan is a plan that covers employees of an employer with at least 100 employees. This special provision does not apply if the person to whom this plan is issued is a retired

employee of the group which arranged for coverage under this plan. This special provision does not apply to a person who is eligible for Medicare by reason of end-stage renal disease.

C. **Eligibility For Medicare By Reason Of End-Stage Renal Disease.** If you are eligible for Medicare by reason of end-stage renal disease, our payment under this plan will not be reduced during the period of time as set forth in the Medicare Law that Medicare is the secondary payer.

7. **Custodial Care.** Custodial care means help in transferring, eating, dressing, bathing, toileting, and other such related activities.

8. **Diagnostic Studies.** Except as otherwise provided in this plan, we will not pay for any hospital stay, or any portion of a hospital stay, which is primarily for diagnostic purposes. This exclusion applies to a hospital stay or a portion of a hospital stay during which the services you receive are primarily for diagnostic x-rays, laboratory tests, or other types of diagnostic studies.

9. **Experimental, Investigational, Or Obsolete Services.** Unless otherwise required by law, or directed pursuant to external review, we will not pay for any otherwise covered treatment, procedure, drug, biological product or medical device (services), or any hospitalization in connection with such services, if such services are experimental, investigational, or obsolete.

   Experimental or investigational means that we determine the service is not of proven benefit for the particular diagnosis or treatment of your particular condition or not generally recognized by the medical community as reflected in the published peer-review medical literature as effective or appropriate for this particular diagnosis or treatment of your particular condition. Obsolete means that the service is not generally used or recognized by the medical community as effective for the particular diagnosis or treatment of your condition.

   Governmental approval of a service will be considered, but is not necessarily sufficient to render a service of proven benefit, or appropriate, or effective for a particular diagnosis or treatment of your particular condition.

   Notwithstanding the provisions of this paragraph, we may provide coverage for experimental or investigational or obsolete services if approved by an External Appeal Agent as described in section 16.

10. **Cosmetic Surgery.** We will not pay for any services in connection with elective cosmetic surgery which is primarily intended to improve your appearance unless a medical necessity determination is rendered after the completion of the utilization review process described in section 16. 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 diseases of the part of the body involved and those services are otherwise covered under this plan. We will also provide coverage for reconstructive surgery because of congenital disease or anomaly of a child covered under this plan which has resulted in a functional defect if those services are otherwise covered under this plan.

    We will provide coverage for surgical services, including all stages of reconstructive surgery, in which a mastectomy has been performed including reconstructive surgical procedures on the unaffected breast to produce a symmetrical appearance if those services are otherwise covered under this plan.

11. **Dental Care.** We will not pay for any services in connection with dental care, including treatment for cavities and extractions, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, dental implants, pathodontia, dental restorative procedures such as crowns, caps, bridges and dentures, braces, extractions, prosthetics, or any form of dental surgery regardless of the reason(s) such services are necessary. We will provide coverage for treatment that is directly related to injuries or accidents involving the jaw or other bone structures adjoining the teeth, or for care

of cancerous lesions, provided such treatment is medically necessary and otherwise covered under this plan. In addition, we will provide coverage for care or treatment in connection with accidental injury to sound natural teeth within 12 months of the accident and treatment necessary due to congenital disease or anomaly as long as the services are otherwise covered under this plan.

12. **Military Service Connected Disabilities.** We will not pay for any service in connection with any military service connected disability if the Veterans Administration has the responsibility to provide the service or care.

13. **Routine Care Of Feet.** We will not pay for any services for routine foot care or any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.

14. **Non-Covered Physical Examinations.** We will not pay for physical examinations such as those required for school, employment, insurance, licensing, travel, or marriage, which are not otherwise medically necessary.

15. **Weight Reduction.** We will not pay for services in connection with weight reduction, dietary control, and nutritional counseling, including but not limited to, stomach stapling and weight loss programs unless they are medically necessary and otherwise covered under this plan. We will not, under any circumstances, pay for commercial weight loss programs or other programs with dietary supplements. We will provide coverage for services related to the treatment of morbid obesity if otherwise covered under this plan.

16. **Non-Covered Benefits.** We will not pay for any services not specifically described in this plan as a covered benefit.

17. **Sex Change.** We will not pay for services or supplies for or related to sex transformations, unless it is determined the transformation is medically necessary and the services are otherwise covered under this plan.

18. **Means To Induce Pregnancy.** We will not pay for services or supplies for or related to in-vitro fertilization, gamete intrafallopian tube transfers, zygote intrafallopian tube transfers, cloning, or medical or surgical services or procedures determined to be experimental. We will not make any payment for or related to donor sperm or the testing or processing of donor sperm.

19. **Organ Transplant Searches, Screening Or Donation.** We will not pay costs relating to searches or screenings for donors of organs to be transplanted. We will pay for covered services directly related to the removal of an organ for transplantation into a person covered under this plan. We will not pay for any services if you are donating an organ for transplantation to a person not covered by this plan.

20. **Drugs, Medicines And Medical Supplies.** We will not pay for drugs, medicines, and disposable medical supplies, except as otherwise described in this plan.

21. **Non-Acute Hospital Or Medically Unnecessary Care.** We will not pay for a Hospital stay or a portion of a hospital stay during which you do not receive acute hospital care or during which you receive care which is not medically necessary. If we deny coverage for these reasons, you may be entitled to an utilization review appeal and external appeal.

22. **Charges For Standby Service.** We will not pay for charges related to a doctor or other medical professional on standby in case their services are needed. We will only provide coverage for charges related to covered services actually performed.

23. **Charges For Services Provided Pursuant To A Prohibited Referral.** We will not pay for clinical laboratory services, x-ray or imaging services, or pharmacy services furnished by any provider pursuant to a referral prohibited by §238-a of the New York State Public Health Law. Generally, §238-a prohibits physicians and other health care practitioners from making referrals for clinical laboratory services, x-ray and imaging services, and pharmacy services

to a provider or facility in which the referring physician or practitioner or an immediate family member has a financial interest or relationship.

24. **Court Ordered Services.** We will not pay for any court ordered services unless they are medically necessary.

25. **Services Maintained By An Employer Or School.** We will not pay for any service or care furnished by a medical department, clinic, or other similar service maintained by your employer or school.

26. **War or Act of War.** We will not pay for any services required as a result of war, regardless of whether the war is declared or undeclared.

27. **Participation in a Felony, Riot or Insurrection.** We will not pay for any services required as a result of participation in a felony, riot or insurrection.

28. **Participation in the Armed Forces or Auxiliary Units of the Armed Forces.** We will not pay for any services required as a result of participation in the Armed Forces or auxiliary units of the Armed Forces.

29. **Suicide, Attempted Suicide, or Intentionally Self-inflicted Injury.** We will not pay for any services required as a result of suicide, attempted suicide, or intentionally self-inflicted injury.

30. **Aviation.** We will not pay for any services required as a result of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

Section Fourteen - Coordination Of Benefits

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays. This is to prevent payments from all group Plans from exceeding 100 percent of the total Allowable Expense.

1. **Definitions.** For purposes of this section, terms are defined as follows:

   A. "Plan" is a form of coverage written on an expense- incurred basis with which coordination is allowed. "Plan" includes:

      1. group insurance and group remittance subscriber contracts;
      2. uninsured arrangements of group coverage;
      3. group coverage through HMO’s and other prepayment, group practice and individual practice plans;
      4. blanket contracts, except as stated below;
      5. the medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contract;.
      6. Medicare or other governmental benefits;
      7. "Plan" does not include individual or family:

         a. insurance contracts;

         b. direct-payment subscriber contracts;

         c. coverage through health maintenance organizations (HMO’s)

         d. coverage under other prepayment, group practice and individual practice plans

         e. State plan under Medicaid

f. a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan

g. blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium

Each contract for coverage described above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. A "Primary Plan" is one whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a Primary Plan if either:

1. the plan either has no order of benefit determination rules, or it has rules which differ from those included in this provision; or

2. all plans which cover the person use the order of benefit determination rules included in this provision and under those rules the plan determines its benefits first.

There may be more than one Primary Plan (for example, two plans which have no order of benefit determination rules).

C. A "Secondary Plan" is one which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this section decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or plans and the benefits of any other plan which, under the rules of this section, has its benefits determined before those of that Secondary Plan.

D. "Allowable Expense" means the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition. Dental care, routine vision care, outpatient prescription drugs, and hearing aids are examples of expenses or services that are not Allowable Expenses under this provision.

When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

E. "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

1. services (including supplies)

2. payment for all or a portion of the expenses incurred

3. a combination of 1 and 2 immediately above.

F. "Claim Determination Period" means a plan year. However, it does not include any part of a plan year during which a person has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect. During each Claim Determination Period Allowable Expenses are compared with total benefits payable in the absence of COB, to determine:

1. whether overinsurance exists

2. how much each plan will pay or provide

As each Claim is submitted, each plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim

Determination Period. But that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

2. **Order of Benefit Determination Rules.** When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

1. coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
2. any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, subscriber or retiree is secondary and the other Plan is primary.
2. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Plan is:
   a. The Primary Plan is the Plan of the parent whose birthday is earlier in a calendar year if the parents are not separated or divorced. The term "birthday" refers to only the month and day in a calendar year, not the year in which a person was born. If both parents have the same birthday, the Plan that covered either of the parents longer is primary. If the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;
   b. If the parents are separated or divorced, the order of benefits is:
      i) the Plan of the custodial parent
      ii) the Plan of the spouse of the custodial parent
      iii) the Plan of the noncustodial parent.
   c. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.
3. Active or inactive employee. The Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a

dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored, provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled 2.D.1.

4. Longer or shorter length of coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is primary. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new plan does not include:

   a. a change in the amount or scope of a plan's benefits

   b. a change in the entity which pays, provides or administers the plan's benefits

   c. a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

5. If a husband or wife is covered under this Plan as a Subscriber and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Plan, this means the Subscriber's benefit will pay first.

3. **Effect on the Benefits of this Plan.** When this Plan is secondary, it will reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. The amount by which this plan's benefits have been reduced will be used by this plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, we will determine our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

4. **Right to receive and release needed information.** Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits.

   We need not tell, or get the consent of, any person to do this except as required by applicable Federal and State laws and regulations. Each person claiming benefits under this Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

5. **Payments to others.** We may make payment to any other person, insurance company or organization for 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 and they satisfy our obligation to you under this plan.

6. **Our right to recover overpayment.** In some cases, we may have made payment to you even though you had coverage under another policy. 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 program if we have not already received payment from that other program. You must sign any document which we feel is needed to help us recover any overpayment.

Section Fifteen - Termination of Your Coverage And Your Right to a New Contract After Termination

1. **Termination of the group plan.** The group plan is provided under the terms of a contract between us and the group contract holder, whose group number is indicated on your identification card. The plan is effective for one year and will automatically be renewed from

year to year unless terminated. Unless expressly stated otherwise below, notices of nonrenewal or termination will provide at least 30 days prior written notice.

A. **Automatic termination.** The plan will automatically terminate as of the date the premium was due if we do not receive the group contract holder's premium on time.

B. **Termination by us.** We may terminate this plan for any of the following reasons:

   1. the contract holder or a participating entity has failed to pay premiums or contributions in accordance with the terms of the contract or we have not received timely premium payments (see "Automatic Termination" above);

   2. the group contract holder or a participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the plan;

   3. if we discontinue the entire class of contracts to which your group plan belongs, we will send the group and covered members written notice that this plan will be terminated at least 90 days in advance of the termination date as required under section 4305(j)(3) of the Insurance Law. This notification will provide further explanation of the group's and member's rights. This termination will be done uniformly, without regard to any health status-related factor, and any groups affected by this discontinuance will be afforded the opportunity to purchase other insurance coverage that is currently made available to, respectively, small or large groups;

   4. there is no longer any enrollee in connection with this plan who lives, works, or resides in our operating area or the area we are authorized to do business;

   5. the group contract holder has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under section 4235 of the Insurance Law;

   6. the group contract holder ceases to meet the requirements for a group under section 4235 of the Insurance Law, or a participating employer, labor union, association or other entity ceases membership or participation in the group to which the contract is issued. This termination will be done uniformly, without regard to any health status-related factor;

   7. if we discontinue all medical insurance coverage in either the small or large group market, we will send the group, members, and the Superintendent written notice that this plan will be terminated at least 180 days in advance of the termination date as required under sections 4305(j)(2)(D) and 4305(j)(3)(B) of the Insurance Law. or;

   8. such other reasons as are acceptable to the Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions or by any federal regulations or rules that implement the provisions of the act.

2. **Termination of the group plan.** Your coverage under this group plan will automatically terminate on the date the group plan terminates. Unless this group plan is replaced by another plan, you may be entitled to purchase a new contract as described within paragraphs 9 or 11 below. In the event you have other than single coverage, the individuals that were covered under your group plan may also be entitled to coverage described within those same paragraphs.

3. **If you are no longer a member of the group.** Your coverage under this plan will automatically terminate on the date to which the premium has been paid if you are no longer a member of the group. For example, if your employment in the group terminates on May 15 and your premium has been paid to June 1, your coverage will terminate on June 1. You may be entitled to purchase a new contract as described within paragraphs 9 or 11 below. In the event you have other than single coverage, the individuals that were covered under your group plan may also be entitled to coverage described within those same paragraphs.

4. **On your death.** Your coverage under this plan will automatically terminate on the date following your death. However, if you have other than single coverage, your coverage under this plan will terminate on the date to which the premium has been paid. In the event you have other than single coverage, the individuals that were covered under your group plan may be entitled to coverage described within paragraphs 9 or 11 below.

5. **Termination of your marriage or domestic partnership.** If you become divorced or your marriage is annulled, or your domestic partnership is dissolved or no longer meets our requirements, the coverage of your wife or husband, or domestic partner, under this plan will terminate on the date the order of divorce or annulment is filed with the County Clerk, or the date the dissolution or disqualification of your domestic partnership is effective. Your former spouse or domestic partner may be entitled to coverage described within paragraphs 9 or 11 below.

6. **Termination of coverage of a child.** The coverage of your child or the child of your domestic partner under this plan will automatically terminate under the conditions and on the date specified within Section 2 of this group plan. The child may be entitled to coverage described within paragraphs 9 or 11 below.

7. **Rescission.** We may rescind your coverage if you commit fraud or make an intentional misrepresentation of material fact. You will be given notice at least 30 days before your coverage is rescinded.

8. **Benefits after termination.**

   A. Except as provided in the paragraph below, upon termination of insurance, whether due to termination of employment, termination of eligibility or termination of the policy, an extension of benefits shall be provided during a period of total disability for hospital confinements commencing or surgery performed during the next 31 days for the injury, sickness or pregnancy causing the total disability.

   B. If this plan is terminated by reason of termination of active employment, an extension of benefits shall be provided during a period of total disability with respect to the sickness, injury or pregnancy which caused the disability, of at least 12 months subsequent to termination of insurance unless coverage is afforded for the total disability under another group health plan.

9. **Temporary continuation of coverage rights.** Pursuant to federal COBRA and state continuation coverage laws, you, your spouse, your children, or anyone else covered under this plan may be able to continue coverage under this group plan in certain situations where you would otherwise lose coverage, known as qualifying events.

   A. If your coverage ends due to voluntary or involuntary termination of employment or membership in the group/class, or reduction in the number of hours of employment, you may continue coverage. Coverage may be continued for you, your spouse, your children, or anyone else covered under this plan.

   B. If you are an eligible spouse, or domestic partner, you may continue coverage if it ends due to:

      1. Voluntary or involuntary termination of the covered employee's/member's employment or membership in the group/class
      2. Reduction in the hours worked by the covered employee/member
      3. Divorce or legal separation of the covered employee/member
      4. Death of the covered employee/member
      5. The covered employee/member becoming entitled to Medicare
      6. Termination of your domestic partnership

C. If you are an eligible child, or child of a domestic partner, you may continue coverage if it ends due to:

    1. Voluntary or involuntary termination of the covered employee's/member's employment or membership in the group/class
    2. Reduction in the hours worked by the covered employee/member
    3. Loss of dependent child status under the plan rules
    4. Death of the covered employee/member
    5. The covered employee/member becoming entitled to Medicare
    6. Termination of the domestic partnership

D. An employee or member who wishes to continue coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of:

    1. The date of the qualifying event; or
    2. The date the employee or member is sent notice by first class mail of the right of continuation by the group policyholder.

E. The policyholder can charge an additional 2% administrative fee for continued coverage.

F. Coverage will terminate at the earliest of the following for any member that elects continuation of coverage:

    1. The date on which the individual becomes entitled to coverage under Medicare.
    2. The date 36 months after your coverage would have terminated because of termination of employment or membership
    3. If you are an eligible dependent, the date 36 months after coverage would have terminated due to the death of the employee or group member, divorce or legal separation, termination of the domestic partnership, the employee or group member's eligibility for Medicare, or the failure to qualify under the definition of "children;
    4. The date on which the individual becomes covered by an insured or uninsured arrangement that provides group hospital, surgical, or medical coverage that does not contain a pre-existing condition exclusion that would affect the individual;
    5. The date to which premiums are paid if you fail to make a timely payment; or
    6. The date the group no longer provides coverage to any of its employees or members.

Call or write your employer or us to find out if you are entitled to temporary continuation of coverage under COBRA or the New York State 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 State Insurance Law.

10. **Supplementary continuation, conversion, and temporary suspension rights.** Under State law, a member of a reserve component of the armed forces of the United States, including the National Guard, who either:

A. voluntarily or involuntarily enters upon active duty (other than for the purpose of determining his or her physical fitness and other than for training), or

B. has his or her active duty voluntarily or involuntarily extended during a period when the president is authorized to order units of the ready reserve or members of a reserve component to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and

C. serves no more than four years of active duty

D. has the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if the group does not voluntarily maintain coverage during the employee's active duty.

When you enter active duty and your employer does not voluntarily maintain your coverage during the period of active duty, coverage under this plan will be suspended during the period of active duty unless you elect to continue coverage under this plan while on active duty. To continue coverage under this plan while on active duty, you must request continuation in writing within 60 days of being ordered to active duty and you must pay the group contract holder the appropriate premium amount in advance of the coverage continuation. If continuation of coverage is elected, member coverage under the plan will terminate on the earlier of the date that the employee, member, or dependent becomes eligible for Medicare or becomes covered as an employee, member, or dependent under any other insured or uninsured group healthcare coverage.

Upon completion of active duty:

E. your coverage under the group plan may be resumed as long as you are reemployed or restored to participation in the group upon return to civilian status. For coverage that was continued while on active duty, coverage under the continuation rights will terminate on the effective date of coverage under the resumed group plan. For coverage that was suspended while on active duty, coverage under the group plan will be retroactive to the date on which active duty terminated.

F. if you are not reemployed or restored to participation in the group upon return to civilian status, then you will be eligible for continuation of coverage under the "Temporary continuation of coverage rights" paragraph above or eligible for conversion of coverage under the "Conversion rights for a direct pay contract" paragraph below so long as you apply to us for coverage within 31 days of the termination of active duty or within 31 days of discharge from a hospitalization resulting from active duty so long as the hospitalization was not in excess of one year.

Call or write your employer or us if you need more information about your rights under section 4305(g) and 4305(h) of the New York State Insurance Law.

11. **Conversion rights for a direct pay contract.**

A. Under section 4305(d) of the Insurance Law, upon termination of a member, an opportunity to purchase the standardized direct pay product described within section 4322 of the Insurance Law will be provided without evidence of insurability under the following circumstances:

1. if you were the subscriber under the group contract for at least 3 months and your coverage within the group plan is terminated for any reason
2. if you were the subscriber under the group contract, the group contract was terminated for any reason, and the terminated group contract was not replaced with continuous and similar coverage on either an insured or self-insured basis
3. if you are the former domestic partner or spouse and your domestic partnership has terminated, you are divorced, or your marriage has been annulled
4. if the subscriber dies and you are the surviving domestic partner, spouse, or dependents under this plan
5. if you were formerly a dependent under this plan, and no longer meet the eligibility requirements as outlined within this plan

B. Additionally, we will not be required to issue the standardized direct pay product described within section 4322 of the Insurance Law to cover any person that appears to have similar benefits as a result of being:

1. covered by another individual contract

2. covered by or eligible for a group contract or policy
3. provided as a requirement by any statute
4. provided by any welfare plan or program which together with the standardized direct pay converted product would result in over-insurance or duplication of benefits according to standards on file with the superintendent of insurance relating to individual contracts.

Notwithstanding the above, if we determine that you do not live, work, or reside in our operating area or in the areas we are authorized to do business, you will not be entitled to purchase a new contract as a direct payment subscriber.

C. When to apply for the new contract. If you are entitled to purchase a new contract as a direct payment subscriber as indicated above, you must apply to us for the new contract according to the following timeframes:

1. within 45 days after termination of your coverage under this plan so long as you receive written notification of your conversion rights from us within fifteen (15) days from the date your coverage under this plan terminated
2. within 45 days from the date you receive written notification of your conversion rights from us, so long as you receive written notification from us more than fifteen (15) days but less than ninety (90) days from the date your coverage under this plan terminated
3. within 90 days from the date you receive written notification of your conversion rights from us, when you receive written notification from us that is more than ninety (90) days from the date your coverage under this plan terminated.

Your payment of premium is due at the same time you apply for coverage.

Section Sixteen - Utilization Review, Adverse Determination, Internal and External Appeals

1. **Utilization Review.**

A. **Prospective reviews.** 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 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 24 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.** 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. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or

your designee) and your provider, by telephone and in writing, within one business day of the earlier of our receipt of the information or 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. **Retrospective Reviews.** If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you (or your designee) 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 submit 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.

2. **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), diagnosis code and treatment code, and corresponding meaning of these codes. 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.

3. **Your Right to an Immediate External Appeal.** If we fail to adhere to the utilization review requirements described in this contract, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external appeal as described in your Certificate.

4. **Home Health Care.** If we receive a request for coverage of home health care services following an inpatient hospital admission, we will notify you (or your designee) and your provider of our decision by telephone and in 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 unless it is a prospective urgent claim for which the prospective urgent claim time frames are applicable.

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

5. **Appeal Time Frames.** You (or your designee) have up to 180 calendar days after you receive notice of the adverse determination to file an 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, where appropriate, your health care provider) 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, where appropriate, your health care provider) 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, home health care services following an inpatient hospital admission, 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 of receipt of the appeal request or two business days of receipt of the necessary information. 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 of receipt of the necessary information for a standard appeal or two business days of receipt of the necessary information for an expedited appeal shall be deemed a reversal of the initial adverse determination.

6. **External Appeal.**

   A. Your Right to an External Appeal. Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

   B. Your Right to Appeal a Determination that a Service is Not Medically Necessary. If the plan has denied coverage on the basis that the service is not medically necessary, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

      1. The service, procedure, or treatment (including clinical trials and treatments for rare diseases) must otherwise be a Covered Service under the Contract; and

      2. You must have received a final adverse determination through the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree to waive any internal appeal.

   C. **Your Right to Appeal a Determination that a Service is Experimental or Investigational.** If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

      1. The service must otherwise be a Covered Service under the Contract; and

      2. You must have received a final adverse determination through the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree in writing to waive any internal appeal.

   In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of your attending physician, has a high probability of 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.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the Plan or one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation - your attending physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or
2. A clinical trial for which you are eligible (only certain clinical trials can be considered).

   For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.
3. A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

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

7. **The External Appeals Process. If, through the Plan’s internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal.** If you and the Plan have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through the Plan’s internal appeal process or its written waiver of an internal appeal.

   You may also request an external appeal application from the New York State Insurance Department at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

   You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent

will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

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

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within three (3) days of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, the Plan will provide coverage subject to the other terms and conditions of this subscriber contract. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

8. **Your Responsibilities.** It is your responsibility to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Insurance Department. You may appoint a representative to assist you with your external appeal request, however, the Insurance Department may contact you and request that you confirm in writing that you have appointed such representative.

   Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. The Plan has no authority to grant an extension of this deadline.

9. **Covered Services/Exclusions.** In general, the Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with this subscriber contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

   If you have any questions, please contact our Customer Service Department listed below. Translation services are available for non-English speaking members:

   BlueShield of Northeastern New York
   PO Box 15013
   Albany, New York 12212-5013
   1-518-220-5800 or toll free at 1-800-459-7587

Service hours: 8:00 a.m. to 7:00 p.m. Monday - Friday

Section Seventeen - General Provisions

1. **No Assignment.** You cannot assign any benefits or monies due under this plan to any person, corporation, or other organization. Any assignment by you will be void. Assignment means the transfer to another person or to an organization of your right to the services provided under this plan or your right to collect money from us for those services.
2. **Notice.** Any notice which we give to you under this plan will be mailed to you at your address as it appears on our records or, if you are covered as a group remittance subscriber, the address of your employer or other organization which sends the premium to us. If you have to give us any notice, it should be mailed to our principal office at BlueShield of Northeastern New York 30 Century Hill Drive Latham New York 12110.
3. **Your Medical Records.** Certain providers and entities often have information we need to administer this plan. As a condition to coverage under this plan, you grant access to us or our designee and permit us to use for our purposes all medical records and other information pertaining to any health related services which you may receive or may have received in the past. Further, you hereby authorize all hospitals, doctors, health care providers, clinics, other providers of health care, other insurers, payers of health claims, other medical or medically related facilities, or government agencies to furnish us with any and all records and other information pertaining to your medical history, services rendered, and treatment received or payments made so we may administer this plan or perform necessary operations as set forth in 11 NYCRR 420.17(b). By accepting this plan you agree to assist us in obtaining your medical records or other information we deem necessary.
4. **Who Receives Payment Under This Plan.** Payments for services provided by a participating provider will be made by us directly to the participating provider. If you receive services from a non-participating provider, or from any other provider of care covered under this plan, we reserve the right to pay either you or the provider.
5. **Time To Sue.** You must start any lawsuit against us under this plan within one year from the date you received the service for which you want us to pay.
6. **Identification Cards.** Identification cards are issued by us for identification only. Possession of an identification card confers no right to services or benefits under this plan. To be entitled to such services or benefits, you must be a paid in full participating member.
7. **Recovery Of Overpayments.** On occasion, a payment will be made to you when you are not covered under this plan, or for a service which is not covered, or in an amount which is more than is proper. When this happens, we will explain the problem to you and you must make arrangements to return the amount of the overpayment to us within 60 days of the date of our advice.
8. **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 have paid benefits as a result of that injury or illness, we have the right independently of you to proceed against the party responsible for your injury or illness to recover the benefits we have paid.

   You have a duty 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. If you fail to cooperate with us in proceeding against the party responsible for your illness or injury, you will be responsible to repay to us the amount of the benefits we have paid and we will have no further obligation to pay benefits associated with that injury our illness. We agree to invoke this penalty only when your illness or injury caused by a third party results in our expenditure on your behalf of an amount in excess of $500 under your coverage.

   New York General Obligations Law (GOL) Section 5-335 provides that a right of subrogation does not apply when a settlement is reached between a plaintiff and defendant

except where there is a statutory right of reimbursement. It further provides that by entering into such settlement, a plaintiff shall not be deemed to have taken an action in derogation of any non-statutory right of any benefit provider that paid medical expenses; nor does a plaintiff's entry into such settlement constitute a violation of any contract between the plaintiff and such benefit provider. In addition, GOL Section 5-335 sets forth the presumption that a settlement between a plaintiff and defendant does not include compensation for the cost of health care services to the extent those expenses are paid or reimbursed by a benefit provider.

9. **Notice Of Claim.** In order for us to process claims for payment under this plan for services provided by a non-participating provider, you or, the non-participating provider who performed the service for you, must sign a claim form provided by us and return the claim form to us within 120 days from the date of service, provided that it was not unreasonable for the for the subscriber to submit the claim within that timeframe. No payment will be made for services received from non-participating providers if we do not receive a claim submission within one year of the date of service. Claim submissions by participating providers shall be governed by our agreement with the participating provider.

10. **Enforceability.** Failure by us to insist upon compliance with any provision of this plan at any given time or under any given set of circumstances shall not operate to waive or modify such provision or in any manner render it unenforceable, as to any other time or as to any other occurrence, whether the circumstances are, or are not the same. No waiver of any of the terms or conditions of this plan shall be valid or of any force or effect unless contained in writing specifically expressing such waiver and signed by a person authorized to sign such waiver.

11. **Translation Services.** Translation services are available under this plan for non-English speaking insured members. Please contact us at the customer service number indicated on your identification card to access these services.

12. **Continuity of Care.**

    A. **Continuity of care when your provider's participation in our network ceases.** If you are being treated on an ongoing basis for a condition or illness by a provider in your network, and your provider leaves the network, you may continue your treatment with the provider for a transitional period. During the transitional period, we will continue to pay for your care as if the provider was still a physician or provider in your network.

        1. **Transitional period of coverage.** In most cases, the transitional period extends up to ninety (90) days from the date you received notice that the provider will no longer be participating with the network. However, if you are in the second or third trimester of pregnancy when your provider leaves the network, the transitional period will extend for as long as you are receiving your post-partum care directly related to the delivery.

        2. **Conditions of coverage.** We will provide coverage of this continued access subject to a treatment plan approved by us if the provider:

            i. meets our quality assurance standards

            ii. agrees to accept as payment in full the payment rates which were in effect while the provider was participating in your network

            iii. agrees to provide to us all necessary information related to the care being rendered to you

            iv. agrees to adhere to all relevant policies and procedures established by us, including rules regarding pre-certification of services

        3. **Exceptions.** We will not cover this care if we have terminated the provider's participation in your HMO network on the grounds that:

i. permitting the provider to continue to treat patients posed a threat of imminent harm to those patients

ii. the provider has committed a fraudulent act

iii. the provider has been the subject of a final disciplinary action by a state licensing board or governmental agency that impairs the provider's ability to practice

B. **Continuity of care when you are a new enrollee.** If you are a new member who has a disabling and degenerative or life-threatening condition or disease, and you are being treated on an ongoing basis by an out-of-network provider at the time of your enrollment, you may continue your treatment with the out-of-network provider for a transitional period. During the transitional period, we will pay for your care as if the provider was a physician or provider in your network.

1. **Transitional period of coverage.** In most cases, the transitional period extends up to sixty (60) days from the date you enrolled under this plan. However, if you are in the second or third trimester of pregnancy at the time you enroll, the transitional period will extend for as long as you are receiving any post-partum care directly related to the delivery.

2. **Conditions of coverage.** We will provide coverage of this continued access subject to a treatment plan approved by us and if the provider:

   i. meets our quality assurance standards

   ii. agrees to accept as payment in full the payment rates established by the plan for services provided by similar providers in your network

   iii. agrees to provide us all necessary information related to the care being rendered to you

   iv. agrees to adhere to all relevant policies and procedures established by us, including rules regarding pre-certification of services

   v. Any coverage we provide related to such care shall be subject to all of the other terms and conditions of this plan

13. **Renewal Date.** This plan shall renew on the 1st day of month of which your plan year began, unless terminated sooner in accordance with this plan.

14. **Plan Amendments.** We may amend this plan at the time of coverage renewal or as otherwise permitted by law, regulation or the Superintendent of Insurance. If we amend your plan as indicated above, we will provide at least 44 days prior written notice to the contract holder or such other notice as permitted by law or the Superintendent of Insurance. By continuing to pay, or have paid on your behalf, the premium for this plan, or continuing to receive services under this plan, you shall be deemed to have accepted any amendments to this plan.

15. **Governing Law.** Unless Federal Law applies, this plan shall be governed by the laws of the State of New York.

This Is Your Traditional Blue Rider for Lifetime Maximum, Annual Maximum, Pre-existing Condition Waiting Period, Emergency Services, Rescission, Utilization Review, and External Appeal Issued by BlueShield of Northeastern New York

This rider amends the paragraphs of your current contract or group plan (policy) issued by BlueShield of Northeastern New York pertaining to lifetime maximum payments by us for in-network and out-of-network benefits, annual maximum payments by us for in-network and out-of-network essential benefits, pre-existing condition waiting periods, emergency service payments by us for out-of-network benefits, rescission, internal utilization review and external appeals.

- **Lifetime Maximum Payments By Us For In-Network and Out-Of-Network Benefits.** Any lifetime dollar limit under current contract or group plan (policy) that place a lifetime dollar limit on benefits under current contract or group plan (policy) are hereby deleted in their entirety.

- **Annual Maximum Payments By Us For In-Network and Out-of-Network Essential Benefits.** Any annual dollar limit under your current contract or group plan (policy) that applies to Essential In-Network and Out-of-Network Benefits, whether such annual limit applies only to an In-Network and Out-of-Network Essential Benefit or includes In-Network and Out-of-Network 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.

- **Pre-Existing Conditions.** Under this Rider, the provision, if any, in your current contract or group plan (policy) that allows us to exclude coverage for Pre-Existing Conditions until a Member has been continuously covered under the current contract or group plan (policy) for a stated period is hereby deleted in its entirety. This provision applies to any current provisions that exclude or otherwise limit coverage for pre-existing conditions.

- **Emergency Services.** The definition of Emergency Condition in your current contract or group plan (policy) is hereby deleted in its entirety and replaced with the following:

A. **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.** A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

C. **Coverage.** Emergency Services are not subject to prior authorization requirements.

D. **Cost Sharing.** Any Copayment or Coinsurance requirement in your current contract or group plan (policy) 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.

- **Rescission.** The provision in your current contract or group plan (policy) regarding rescissions is hereby deleted and replaced with the following:

  Rescission. We may rescind your coverage if you commit fraud or make an intentional misrepresentation of material fact. You will be given notice at least 30 days before your coverage is rescinded.

- **Utilization Review.** The following changes are made to the Utilization Review paragraph in your current contract or group plan (policy):

A. The provisions in your current contract or group plan (policy) describing time frames for making initial utilization review determinations are deleted in their entirety and replaced with the following:

Prospective Reviews. 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 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 24 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.

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. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business day of the earlier of our receipt of the information or 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 time frames 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.

Retrospective Reviews. If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you (or your designee) 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 submit 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.

B. The paragraph in your current contract or group plan (policy) 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), diagnosis code and treatment code, and corresponding meaning of these codes. 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.

C. The following new subparagraph is hereby added to the Utilization Review paragraph in

your current contract or group plan (policy):

Your Right to an Immediate External Appeal. If we fail to adhere to the utilization review requirements described in your Certificate, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external appeal as described in your Certificate.

D. If we receive a request for coverage of home health care services following an inpatient hospital admission, we will notify you (or your designee) and your provider of our decision by telephone and in 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 unless it is a prospective urgent claim for which the prospective urgent claim time frames are applicable.

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

E. The appeal time frames in your current contract or group plan (policy) are hereby deleted in their entirety and replaced with the following:

You (or your designee) have up to 180 calendar days after you receive notice of the adverse determination to file an 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, where appropriate, your health care provider) 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, where appropriate, your health care provider) 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, home health care services following an inpatient hospital admission, 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 of receipt of the appeal request or two business days of receipt of the necessary information. 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 of receipt of the necessary information for a standard appeal or two business days of receipt of the necessary information for an expedited appeal shall be deemed a reversal of the initial adverse determination.

- **External Appeal.** The following changes are made to the External Appeal paragraph in your current contract or group plan (policy):

    Your Right to an External Appeal: Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

    Your Right to Appeal a Determination that a Service is Not Medically Necessary. If the plan has denied coverage on the basis that the service is not medically necessary, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

    A. The service, procedure, or treatment must otherwise be a Covered Service under the Subscriber Contract; and

    B. You must have received a final adverse determination through the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree to waive any internal appeal.

    Your Right to Appeal a Determination that a Service is Experimental or Investigational. If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

    A. The service must otherwise be a Covered Service under this Subscriber Contract; and

    B. You must have received a final adverse determination through the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree in writing to waive any internal appeal.

    In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of your attending physician, has a high probability of 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.

    Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the Plan or one for which there exists a clinical trial or rare disease treatment (as defined by law).

    In addition, your attending physician must have recommended one of the following:

    A. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered

in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or

B. A clinical trial for which you are eligible (only certain clinical trials can be considered).

   For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

C. A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

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

The External Appeals Process. If, through the Plan's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through the Plan's internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application form the New York State Insurance Department at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend of confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

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

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited

external appeal. In that case, the external appeal agent must make a decision within three (3) days of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, the Plan will provide coverage subject to the other terms and conditions of this subscriber contract. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care service, the cost of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial. The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

Your Responsibilities. It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Insurance Department. You may appoint a representative to assist you with your external appeal request, however, the Insurance Department may contact you and request that you confirm in writing that you have appointed such representation.

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. the Plan has no authority to grant an extension of this deadline.

Covered Services/Exclusions. In general, the Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with the subscriber contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

- **New Contract.** The new contract to which you may be entitled if your coverage under your BlueShield of Northeastern New York contract or group plan terminates may not contain the benefits provided by this rider.

- **Other Provisions.** All of the other provisions contained in your contract or group plan apply to this rider, except as specifically changed by this rider.

BlueShield of Northeastern New York
30 Century Hill Drive
Latham, New York 12110

President & CEO

OPEIU 212
UNION LABEL

BlueShield of Northeastern New York

A Division of HealthNow New York Inc.

An Independent Licensee of the BlueCross BlueShield Association

This Is An Amendment to Your Traditional Blue Group Plan

This amendment to your Traditional Blue group plan with BlueShield of Northeastern New York changes your current benefits as follows.

1. Under the **"Who Is Covered"** section, benefits referring to coverage of a domestic partner's child(ren), the following statement now applies:

   A. **A Domestic partner's child(ren) covered.** The child(ren) of your domestic partner are eligible for coverage under this plan if any of the following requirements are met:

   - the unmarried dependent children of your domestic partner meet the eligibility requirements that apply to the subscriber's natural or adopted children;
   - you legally adopt them;
   - you have filed to adopt them and they are legally dependent upon you during the waiting period prior to adoption becoming final; or
   - you become appointed their legal guardian by court order.

   The dependent(s)' coverage will terminate in accordance with the stipulations set forth in the "Who Is Covered" section of the group plan, upon termination of the group plan, or upon termination of the domestic partnership.

   The subscriber must notify us in the event any of the requirements for coverage of the child(ren) of the domestic partner cease to be satisfied. We reserve the right to verify that the dependent(s) meet(s) the eligibility requirements of the plan.

2. **New Contract.** The new contract to which you may be entitled if your coverage under your BlueShield of Northeastern New York group plan terminates may not contain the benefits provided by this Amendment.

3. **Other Provisions.** All of the provisions contained in your BlueShield of Northeastern New York group plan apply to this Amendment, except as specifically changed by this Amendment.

BlueShield of Northeastern New York
30 Century Hill Drive
Latham, New York 12110

President & CEO

OPEIU 212

UNION LABEL

This Is Your Rider for Autism Spectrum Disorder Issued By BlueShield of Northeastern New York

This rider amends the paragraphs of your current contract or group plan (policy) issued by BlueShield of Northeastern New York pertaining to Autism Spectrum Disorder.

1. **Autism Spectrum Disorder.** We will provide coverage for the screening, diagnosis and treatment of Autism Spectrum Disorder. Coverage will be subject to annual deductibles, copayments and coinsurance. Applied behavior analysis will be covered at the specialist coinsurance identified by your plan and shall be subject to a maximum benefit of $45,000 per year per covered individual and such maximum annual benefit will increase by the amount calculated from the average 10 year rolling average increase of the medical component of the consumer price index. Coverage shall be subject to utilization review, external appeals of Health Care Services, Case Management, and other managed care provisions set forth in your contract.

2. **Diagnosis of Autism Spectrum Disorder.** We will provide coverage for assessments, evaluations, or tests to diagnose whether an individual has Autism Spectrum Disorder.

3. **Treatment of Autism Spectrum Disorder.** We will provide coverage for the following care and assistive communication devices prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist:

   A. Behavioral Health Treatment

   B. Psychiatric Care

   C. Psychological Care

   D. Medical Care provided by a licensed health care provider

   E. Therapeutic Care, including therapeutic care which is deemed habilitative or non-restorative, in the event that the policy provides coverage for therapeutic care.

   F. Pharmacy Care in the event that the contract provides coverage for prescription drugs.

   G. Assistive Communication Devices. 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. Our coverage is limited to dedicated devices; we will only cover devices that generally are not useful to a person in the absence of a communication impairment. 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. Coverage will be subject to annual deductibles, copayments and coinsurance. Assistive communication devices will be subject to your specialist coinsurance identified within your plan. These devices shall be approved in advance by our medical director for as long as our medical director determines that it is medically necessary. Repair, replacement, fitting and adjustments are covered, when made necessary by normal wear and tear or significant change in a member's physical condition. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered.

4. **Definitions of Terms.**

   A. **Autism Spectrum Disorder.** Any pervasive developmental disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's Disorder, Rett's Disorder, Childhood Disintegrative Disorder, or Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS).

   B. **Applied Behavior Analysis.** 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.

   C. **Behavioral Health Treatment.** Counseling and treatment programs, when provided by a licensed provider, and applied behavior analysis, when provided or supervised by a behavior analyst certified pursuant to the behavior analyst certification board, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. Individuals that provide behavioral health treatment under the supervision of a certified behavior analyst pursuant to this subsection shall be subject to standards of professionalism, supervision and relevant experience pursuant to regulations promulgated by the superintendent in consultation with the commissioners of health and education.

   D. **Pharmacy Care.** Medications prescribed by a licensed health care provider legally authorized to prescribe under Title Eight of the Education Law.

   E. **Psychiatric Care.** Direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

   F. **Psychological Care.** Direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

   G. **Therapeutic Care.** Services provided by licensed or certified speech therapists, occupational therapists, social workers, or physical therapists.

5. **Limitations.**

   A. Coverage may be denied on the basis that such treatment is being provided to the covered person pursuant to an individualized education plan under Article 89 of the Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized service plan pursuant to regulations of the Office for Persons With Developmental Disabilities shall not affect coverage under the policy for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed physician or licensed psychologist.

   B. We will not provide coverage for assistive communication devices that are not exclusively dedicated to speech generation. For example, we will not cover items, such as, but not limited to, laptops, desktops, or tablet computers.

6. **General Provisions.** This rider does not affect the following coverage:

   A. Nothing in this rider shall be construed to affect any obligation to provide services to an individual under an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

   B. Nothing in this rider shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235A of Article 43 or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

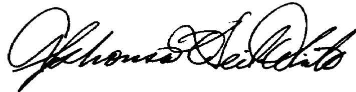
   C. Nothing in this rider shall be construed to prevent a contract from providing services through a network of participating providers who shall meet certain requirements for participation, including provider credentialing.

7. **New Contract.** The new contract to which you may be entitled if your coverage under your contract or group plan terminates may not contain the benefits provided by this rider.

8. **Other Provisions.** All of the other provisions contained in your contract or group plan apply to this rider, except as specifically changed by this rider.

BlueShield of Northeastern New York

30 Century Hill Drive
Latham, New York 12110



President & CEO

This Is Your Rider for Women's Preventive Services Issued By BlueShield of Northeastern New York

This rider amends the paragraphs of your current contract or group plan (policy) issued by BlueShield of Northeastern New York pertaining to women's preventive service payments by us for in-network benefits.

1. Women's Preventive Services. To the extent items and services in the sources referenced below are not already covered benefits for women under your current contract or group plan (policy), the items and services are hereby added to your current contract or group plan (policy).

   A. Well-women annual preventive care visit that are age and developmentally appropriate, including preconception and prenatal care.

   B. Screening for gestational diabetes. We will cover screening in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

   C. Human papillomavirus testing. We will cover the screening for human papillomavirus, which will begin at 30 years of age and will occur no more frequently than every 3 years.

   D. Annual counseling on sexually transmitted infections.

   E. Annual counseling and screening for human immune-deficiency virus infection.

   F. Annual counseling and screening for interpersonal and domestic violence.

   G. Breastfeeding support, supplies and counseling covered in conjunction with each birth. We will cover rental of breastfeeding equipment and comprehensive lactation support and counseling by a trained provider during pregnancy or in the postpartum period.

   H. Sterilization procedures, patient education, counseling, and contraceptive drugs and devices or their generic equivalents, which are approved by the Federal Drug Administration (FDA) and require a prescription in order to be sold to you. We will provide full coverage for brand name contraceptive drugs, only if there is not a generic equivalent available. Our coverage of medical procedures, education, counseling and contraceptives will not extend beyond the current coverage of your contract. The covered drugs are required by law to have a label stating "Caution, Federal Law Prohibits Dispensing without a Prescription." The covered drugs and devices must be prescribed by a physician or provider legally authorized to prescribe drugs under Title VIII of the Education Law. Coverage does not include abortifacient drugs.

   The preventive services referenced above shall be covered in full when received from In-Network Providers. Cost sharing (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. A list of preventive items and services covered under this paragraph is available on our website at www.bsneny.com or will be mailed upon request. You may call customer service at the number provided on your identification card to request further information.

2. New Contract. The new contract to which you may be entitled if your coverage under your contract or group plan terminates may not contain the benefits provided by this rider.

3. Other Provisions. All of the other provisions contained in your contract or group plan apply to this rider, except as specifically changed by this rider.

BlueShield of Northeastern New York
30 Century Hill Drive
Latham, New York 12110

President & CEO

BlueShield
of Northeastern New York
A Division of HealthNow New York Inc.
An Independent Licensee of the BlueCross BlueShield Association

This Is Your Traditional Blue Vision Rider Issued By BlueShield of Northeastern New York

This rider provides additional coverage to your BlueShield of Northeastern New York Contract or Group Plan.

1) **Definitions.**

   A. **Eye Examination** means a comprehensive examination, including dilation as professionally indicated, of the visual functioning to determine the presence of visual problems and/or other ocular abnormalities, including the prescription of corrective eyewear.

   B. **Lenses** means covered plastic or glass ophthalmic corrective lenses prescribed by an ophthalmologist or optometrist, to be fitted into ophthalmic frames.

   C. **Contact Lenses** means covered ophthalmic corrective lenses on our formulary up to a $105 retail value, (including both soft/standard and disposable/planned replacement) prescribed by an ophthalmologist or optometrist to be fitted on your eyes. Certain contact lenses may be designated as "non-plan lenses".

   D. **Frames** means standard eyeglass frames from the Designer Selection for two spectacle lenses.

   E. **Participating Provider** means a duly licensed optometrist, a duly licensed ophthalmologist or a duly licensed optician who has a written agreement with a delegated entity to provide covered services to our members covered under this rider.

2) **Covered Services.** Under this rider we will provide benefits for eye examinations with dilation as professionally indicated, spectacle lenses and frames or contact lenses as outlined below.

   A. **Eye Examination.** We will make payment for an initial eye examination with dilation as professionally indicated, minus any copayment, after you become covered under this rider and for subsequent eye examinations per calendar year.

   B. **Spectacle Lenses / Contact Lenses.** We will make payment for one pair of prescription lenses per calendar year, either spectacle or a supply of contact lenses but never both. This includes, but is not limited to: single vision; bifocal; trifocal; and lenticular spectacle lenses; hard, soft, gas permeable daily wear or disposable contact lenses. Additional lens options, such as progressive no-line bifocals and photochromic lenses are available at discounted prices and are paid for by you, the member, at the time of service.

C. **Frames.** We will make payment for one frame from the Designer Collection per calendar year. Our allowance includes the services directly related to facial measurements; determination of interpupillary distance; assistance in selecting frames; fitting; adjustments; and aftercare for comfort.

3) **Copayments.**

A. **Services Provided by Participating Providers.**

1. Eye Examination - You will be required to make a $0 copayment toward the cost of an eye examination.

2. Eyeglasses (Frame and Lenses) / Contact Lenses - No copayment is required for eyeglasses or contacts.

B. **Non-Covered Services.** Any charges for non-covered services are your responsibility.

4) **Exclusions.** No benefits shall be provided under this rider for:

A. Vision Services received or prescribed before the effective date of coverage, or ordered after termination of coverage.

B. Examinations; frames; or lenses which are not necessary according to accepted standards of ophthalmic practice or which are not ordered or prescribed by the attending physician or by the optometrist.

C. Replacement of lost; stolen; broken; or damaged lenses, contact lenses or frames, unless at the time of replacement the Subscriber is otherwise entitled to benefits for the lenses or frames.

D. Industrial safety glasses; safety goggles; or sunglasses; whether or not they require a prescription.

E. Examinations; frames; or lenses required by the Subscriber's employment.

F. Examinations; lenses; or frames for which benefits are afforded in whole or in part, under a Workers' Compensation Act or like laws; whether or not the Subscriber claims or receives benefits thereunder, and regardless of whether the Subscriber recovers any damages against a third person.

G. Duplication of services: The benefits covered under this amendment are reduced by any benefits received under your contract or group plan.

5) **New Contract.** The new contract to which you may be entitled if your coverage under your Contract or Group Plan terminates may not contain the benefits provided by this rider.

6) **Other Provisions.** All of the other provisions contained in your contract or group plan apply to this rider, except as specifically changed by this amendment.

BlueShield of Northeastern New York
30 Century Hill Drive
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President & CEO

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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 sets forth BlueShield of Northeastern New York's legal obligations concerning your Protected Health Information (PHI) and your non-public, personal financial information (collectively, "Information"). Additionally, this Notice describes your rights to access and control your Information.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a healthcare provider, a health plan, your employer or a healthcare clearinghouse and that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of healthcare to you; or (3) the past, present or future payment for the provision of healthcare to you. Non-public personal financial information is personally identifiable financial information and any list or description of consumers (and publicly available information pertaining to them) that is derived using any personally identifiable financial information other than publically available information.

This Notice of Privacy Practices has been drafted to be consistent with the federal regulation known as the "HIPAA Privacy Rules," and Title 11, Part 420 of the New York Codes, Rules and Regulations (11 NYCRR 420) as well as applicable provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, as incorporated in the American Recovery and Reinvestment Act of 2009. Any of the terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rules or 11 NYCRR 420.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your Information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your Information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect October 1, 2010, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law.

We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all Information that we maintain, including Information we created or received before we made the changes. If we make a significant change in our privacy practices we will revise this Notice and send the new Notice to our health plan subscribers.

You may ask for a paper 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 information listed at the end of this Notice.

Organizations Covered by This Notice

If your coverage is through a group health plan and we determine that an organized healthcare arrangement exists between BlueShield of Northeastern New York and your group

health plan, BlueShield of Northeastern New York's and your group health plan may share your Information with each other as needed for the payment activities or healthcare operations relating to our organized healthcare arrangement.

Our Privacy Principles and Security Procedures

We take the privacy and security of your Information seriously and we take numerous precautions to protect it. Information in oral, written and electronic form is protected by establishing and enforcing security and privacy policies and procedures, implementing security and privacy awareness training for all workforce members, and deploying appropriate physical, administrative, and technical safeguards to protect your Information.

We do not sell your Information. We do not provide your Information to persons or organizations outside of our company for their own marketing purposes. We restrict and limit employee access to your Information only to those who need it to carry out their business functions. We educate our employees about safeguarding your Information and preventing its unauthorized access, disclosure or use. We contractually require any person or organization providing products or services to you on our behalf to protect the confidentiality and limit the use of your Information in a manner consistent with our Privacy Policy. We maintain a combination of physical, electronic and organizational safeguards to protect and prevent unauthorized access to your Information that comply with Federal standards to guard nonpublic personal information about you. We do not release any information about current or former customers to non-affiliated third parties, except as permitted by law. We will afford prospective, existing and former customers the same protections with respect to the use of their Information.

Information We May Collect and Share with Others

We may collect Information from you that we believe is necessary to administer our business and to provide you with health insurance products and services. In order to issue and administer your policy or coverage, we may also need to disclose this Information with non-affiliated third parties as described in this notice. The types of information we may collect and disclose include (1) information we receive from applications for insurance coverage or services from you or your employer or plan sponsor, such as names, addresses, social security numbers, phone numbers, and dates of birth for you and your dependents; (2) information we receive from you or your employer or plan sponsor on other forms; (3) information about your transactions with us or others (such as health care providers) regarding your medical information or claims; and (4) information we receive from you in person, by phone, by e-mail or through visits to our web site and browser interaction with us.

Uses and Disclosures of PHI

Once you become our customer or claimant, we may use your Information and disclose it to affiliated and non-affiliated third parties for treatment, payment and healthcare operations and other purposes outlined in this Notice. These parties are required to maintain the confidentiality of our customer Information. Such uses and disclosures allow us to issue your health insurance policy or coverage, process your claims, ensure proper billing and otherwise administer your coverage. We also use the Information as otherwise required or permitted by Federal and State law. Below we provide examples of the types of uses or disclosures that fall within a particular category. These examples are intended to help you understand what these categories mean. They do not cover every type of use or disclosure within each category.

TREATMENT. We may disclose your Information for treatment purposes. For example, we may disclose your Information to a physician or other healthcare provider so they can provide treatment to you.

PAYMENT. We may use and disclose your Information for payment purposes. For instance, we may use and disclose your Information to pay claims from physicians, hospitals and other providers for services delivered to you that are covered by your health plan or your policy. We may also use and disclose your Information to determine your eligibility for benefits, to coordinate benefits, to determine medical necessity, to obtain premiums and to issue explanations of benefits to the subscriber of the health plan or insurance policy under which you are covered. In addition, we may disclose your Information to a healthcare provider or entity subject to the HIPAA Privacy Rules or 11 NYCRR 420 (such as another health insurer or HMO) so they can obtain payment or engage in these payment activities.

HEALTHCARE OPERATIONS. We may use and disclose your Information in connection with our healthcare operations. Healthcare operations include, but are not limited to: (1) rating our risk and determining our premiums for your health plan or policy; (2) quality assessment and improvement activities; (3) reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities; (4) medical review, legal services and auditing, including fraud and abuse detection and compliance; (5) business planning and development; and (6) business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances and creating de-identified PHI or a limited data set.

We may disclose your Information to another entity that has a relationship with you and is subject to the HIPAA Privacy Rules or 11 NYCRR 420 for its healthcare operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals or detecting or preventing healthcare fraud and abuse.

BUSINESS ASSOCIATES. We work with business associates who perform various functions on our behalf or provide certain types of services for us. To perform these functions or to provide the services, business associates will receive, create, maintain, use or disclose Information, but only after the business associate enters into a written agreement with us in which the business associate agrees to appropriately safeguard your Information in accordance with the HIPAA Privacy Rules or 11 NYCRR 420. For example, we may disclose your Information to a business associate to administer claims, manage our pharmacy benefit or provide member service support.

TO YOUR FAMILY AND FRIENDS. We may disclose your Information to a family member, friend or other person if it helps with your healthcare or with payment for your healthcare. We may use or disclose your Information so that your family can be notified about your location and general condition.

Before we disclose your Information to anyone involved in your healthcare or payment for your healthcare we will provide you with an opportunity to object. If we cannot locate you or if you are unable to respond because of an emergency, we will disclose your Information when based on our professional judgment the disclosure would be in your best interest.

YOUR EMPLOYER OR ORGANIZATION SPONSORING YOUR GROUP HEALTH PLAN. Your Information is not released to employers unless you have authorized the release and/or the proper agreements are in place as permitted by law. If your coverage is through a group health plan, we may disclose your Information to the group health plan or its authorized agents or representatives. In addition, if permitted by the terms of the group health plan, we may disclose your Information to your employer or organization that sponsors your group health plan to permit the plan sponsor to perform plan administration functions. Please

see your group health plan document for a full explanation of the limited disclosures of Information to the plan sponsor and uses that the plan sponsor may make of your Information in providing plan administration. PHI will be disclosed to the plan sponsor only if the plan sponsor certifies that it will use and disclose the PHI in accordance with the HIPAA Privacy Rules.

We may disclose limited enrollment and disenrollment information to the plan sponsor of your group health plan or its authorized agents or representatives. We may also disclose summary information as defined in the HIPAA Privacy Rules to the plan sponsor or its authorized agents or representatives, to use to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan. The summary information we may disclose summarizes claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. The summary information will be stripped of demographic information about the enrollees in the group health plan, but the plan sponsor may still be able to identify enrollees in your group health plan from the summary information.

UNDERWRITING. If we receive your Information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits ("underwriting"), we will not use or further disclose this Information for any other purpose, except as required by law, unless and until you are covered for health insurance or health benefits with us. In that case, we will follow the rules of use and disclosure described in this Notice. If genetic information is included as a subset of the Information received for underwriting purposes, we will not use or disclose the genetic information for these purposes. Genetic information is information with respect to an individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual, but information about the sex or age of any individual shall be used in accordance with state law or regulation.

DISASTER RELIEF. We may use or disclose your Information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

REQUIRED BY LAW. We may use or disclose your Information to the extent that we are required to do so by law. For example, we may disclose your Information when required by national security laws or public health disclosure laws.

PUBLIC HEALTH ACTIVITIES. We may disclose your Information for public health activities that are permitted or required by law. For example, we may disclose information to help prevent or control disease, injury or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect.

HEALTH OVERSIGHT ACTIVITIES. We may disclose your Information to a health oversight agency for oversight activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative or criminal proceedings or

actions. Oversight agencies include government agencies that oversee: (1) the healthcare system; (2) government benefit programs; (3) other government regulatory programs; and (4) compliance with civil rights laws.

ABUSE OR NEGLECT. We may disclose your Information to the appropriate authorities if we reasonably believe that you have been a victim of abuse, neglect or domestic violence.

LEGAL PROCEEDINGS. We may disclose your Information in the course of any judicial or administrative proceeding: (1) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); or (2) in response to a subpoena, a discovery request or other lawful process, if we have received satisfactory assurances from the party seeking the PHI in accordance with the HIPAA Privacy Rules or 11 NYCRR 420.

LAW ENFORCEMENT. Under certain conditions, we also may disclose your Information to law enforcement officials. Some of the reasons for such a disclosure include, but are not limited to: (1) the disclosure is required by law or some other legal process; (2) the disclosure is necessary to find or identify a suspect, fugitive, material witness or missing person; or (3) the disclosure is necessary to provide evidence of a crime that occurred on our premises.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS AND ORGAN DONATION. We may disclose Information to a coroner or medical examiner to help identify a deceased person, determine a cause of death or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose Information to organizations that handle organ, eye or tissue donation and transplantation.

RESEARCH. We may disclose your Information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research as part of a limited data set which includes no unique identifiers (information such as name, address, Social Security number, etc. that can identify you).

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY. Consistent with applicable federal and state laws, we may disclose your Information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose Information if it is necessary for law enforcement authorities to identify or apprehend someone.

MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES. Under certain conditions, we may disclose your Information if you are, or were, an Armed Forces personnel if the disclosure is for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. If you are a member of a foreign military service, we may disclose, in certain circumstances, your Information to the foreign military authority. We also may disclose your Information to authorized federal officials for conducting national security and intelligence activities.

INMATES. If you are an inmate of a correctional institution, we may disclose your Information to the correctional institution or to a law enforcement official for: (1) the institution to provide healthcare to you; (2) your health and safety and the health and safety of others; (3)

law enforcement at the correctional institution; or (4) the safety and security of the correctional institution.

WORKERS' COMPENSATION. We may disclose your Information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

HEALTH-RELATED SERVICES. We may use your Information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your Information to a business associate to help us with these activities.

We may use or disclose your Information to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts of nominal value.

SPECIAL TREATMENT OF CONFIDENTIAL HIV-RELATED INFORMATION. Certain state laws require that we limit how we disclose confidential HIV-related information we may have received about you. "Confidential HIV-Related Information" includes information concerning whether an individual has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which could reasonably identify a person as having one or more of such conditions. In general, unless we obtain a written authorization from you, we will only disclose such information as provided for in applicable laws. Some of the purposes for which applicable state laws permit us to disclose such information are as follows: to providers engaged in your care or the care of a person that may have been exposed to HIV; certain healthcare facilities or providers involved in organ, tissue and similar transplants; federal, state, county or local health officers; authorized agencies involved in foster care or adoption of a child; other third-party reimbursers involved in the payment of healthcare; and pursuant to a court order.

SPECIAL TREATMENT OF CERTAIN MENTAL HEALTH INFORMATION. Certain laws may restrict how we disclose certain clinical records containing mental health information we may receive from healthcare providers. Unless we obtain a written authorization, we will limit our disclosures of this information to that permitted by applicable laws.

SPECIAL TREATMENT FOR CERTAIN SUBSTANCE ABUSE RECORDS AND INFORMATION. Certain laws may restrict how we disclose Information about you that pertains to treatment you may have received for alcohol or drug dependency. Unless we obtain a written authorization, we will limit our disclosures of this information to that permitted by applicable laws.

Individual Rights

ACCESS. You have the right to look at or get copies of your Information that is contained in a "designated record set." Generally, a designated record set contains medical and billing information as well as other records that are used to make decisions about your healthcare benefits. The HIPAA Privacy Rules do not permit the inspection or copying of psychotherapy notes or certain other information that may be contained in a designated record set. You may ask for copies in a format other than photocopies. We will use the format you request unless it is not practical to do so.

You must obtain a form to request access to your Information by using the contact information at the end of this Notice. If you request copies, we may charge you a reasonable fee for copies, a reasonable rate for staff time to copy your Information and postage if you want the copies mailed to you. If you request an alternative format, we may charge a reasonable fee for providing your Information in that format. If you prefer, we will prepare a summary or an explanation of your Information. If you request a summary, you may be charged a reasonable rate for staff time to prepare the summary. If your request for access is denied, we will provide a written statement explaining the denial, a statement of any applicable review rights and a description of our complaint procedures. In certain circumstances, our denial will not be reviewable. If this occurs, we will inform you in the denial statement that our decision is not reviewable.

We do not generate or modify, nor do we maintain complete copies of your medical records. We may receive copies of portions of your medical records in order to process claims and perform other routine functions in the normal course of business. If you want to obtain copies of your medical records, you should contact the practitioner or facility considered to be the source of these documents.

DISCLOSURE ACCOUNTING. You have the right to receive a list of instances in which we or our business associates disclosed your Information for purposes other than treatment, payment or healthcare operations, and for certain other activities (and where such recording or accounting is required by the HITECH Act). You must obtain a form to request an accounting by using the contact information at the end of this Notice. Your request can be for disclosures made up to six years before the date of your request. 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 Information, a description of the Information we disclosed, the reason for the disclosure and certain other information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee for responding to these additional requests.

In addition, if you contact any of our business associates directly based on information we provide you and where so required by the HITECH Act and/or any accompanying regulation, business associate shall make such disclosure information available directly to you.

RESTRICTION. You have the right to request that we place additional restrictions on our use or disclosure of your Information. You must obtain a form to request a restriction by using the contact information at the end of this Notice. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except when necessary for treatment in an emergency). Any agreement to additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be bound unless we have a signed, written agreement.

CONFIDENTIAL COMMUNICATION. You have the right to request that we communicate with you about your Information by alternative means or that we send your Information to alternative locations. You must make your request in writing, and you must state that the disclosure of information could endanger you if it is not communicated in confidence as you request. We must accommodate your request if it is reasonable, specifies the alternative means or location and continues to permit us to collect premiums and pay claims under your health plan or insurance policy, including issuance of explanations of benefits to the subscriber of the health plan or insurance policy under which you are covered. Please note that it may take a short period of time for us to accommodate your request.

Once a request for confidential communications goes into effect, all your Information will be processed as you requested. We will not process requests on a diagnostic-specific basis. This

means that we cannot process a request to withhold only the Information relating to a specific condition, diagnosis or treatment. Therefore, all documents that might contain Information about services you receive (such as letters or explanations of benefits) will be addressed to you and not the subscriber. The subscriber will still be entitled to access billing information and other Information in connection with the health plan or insurance contract.

Importantly, even if you request confidential communications: (1) the check for services you receive from a nonparticipating provider could be sent to you but made payable to the subscriber, unless you have made other payment arrangements with us; and (2) accumulated payment information such as deductibles (in which your Information might appear), will continue to appear on all future explanations of benefits sent to the contract holder. We urge you to discuss with us how we can arrange to pay your claims for services that you receive from a nonparticipating provider.

If you terminate your request for confidential communications, the restriction will be removed for all your Information that we hold, including Information that we previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your Information will endanger you.

AMENDMENT. You have the right to request that we change your Information. Your request must be in writing and it must explain why the information should be changed. We may deny your request if we did not create the information you want changed and the originator remains available or for certain other reasons (for example, BlueShield of Northeastern New York maintains that the record in question is accurate and complete). If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to inform others, including people you name, of the change and to include the changes in any future disclosures of that information.

AUTHORIZATIONS. An authorization is not required for treatment, payment or health care operations and in other instances as required by law. You have the right to authorize representatives to act on your behalf with respect to your Information. You must obtain a form to identify your authorized representatives and explain what type of Information they may receive. You may request this form by using the contact information at the end of this Notice or visiting our Web site.

You have the right to revoke an authorization except to the extent that we have taken action in reliance on the authorization. By using the contact information at the end of this Notice, you may obtain a revocation form. We will not, with some exceptions, disclose your Information without your authorization or as otherwise described in this Notice.

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 information listed at the end of this Notice to obtain this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this Notice. Requests sent to persons, offices or addresses other than the one indicated might result in a delayed response.

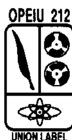
We support your right to the privacy of your Information. If you believe your privacy rights have been violated, you may file a complaint with us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Secretary of the Department

of Health and Human Services. We will provide you with the address to file your complaint with the Secretary of the Department of Health and Human Services upon request. We will not retaliate in any way in response to the filing of a complaint.

Contact Office: BlueShield of Northeastern New York
Telephone: 1-800-459-7587
Address: PO Box 80, Buffalo, New York 14240

Contact Office: State Government Programs
Telephone: 1-866-231-0847
Address: PO Box 80, Buffalo, New York 14240

Contact Office: Medicare Advantage
Telephone: 1-800-329-2792
Address: PO Box 80, Buffalo, New York 14240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