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	0002	PPO1N000	P3C03E23
00969603	0002	PPO1NM00	P3D03E23

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 **Account Specialist:** 17

123 Main Street **Invoice ID:** 987654321098

Any Town, NY 14444-4444 **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 Preferred Provider Group Plan for Employees or Members of Fulmont Health Trust - Wells

This booklet explains the benefits available to you under a contract between BlueShield of Northeastern New York and the group whose name and/or number is listed on your Identification Card. This booklet is issued to the person named on the Identification Card. The Plan will continue unless it is terminated for any of the reasons described in this booklet. Your coverage under this Plan begins on the effective date shown on the Identification Card.

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

President & CEO

Table of Contents

Section One - Introduction

1. **Coverage Under This Plan.**

   A. **In-Network Benefits.** To receive coverage for In-Network Benefits, the services MUST meet ONE of the requirements below:

   - The services must be provided by a Preferred Provider A "Preferred Provider" is a Hospital, facility, physician, or other provider with an agreement with us regarding payment for In-Network covered services under this Plan.
   - You receive emergency care covered under Section Eight of this Plan.

   In-Network Benefits are described in Sections Three through Ten of this Plan.

   B. **Out-Of-Network Benefits.** If you receive care which does not meet either of the requirements for In-Network Benefits, you will only be entitled to receive the Out-Of-Network Benefits which are described in Section Eleven of this Plan. Some services covered under this Plan, such as routine physicals, are only covered if received from a Preferred Provider and are not covered as Out-Of-Network Benefits.

2. **Your Coverage Under The Group Plan.** The organization whose name and/or number is listed on your Identification Card (referred to as the Group Contract Holder) has purchased a group health insurance contract from us. Under that contract, we will provide the benefits described in this booklet to members of the group. The benefits provided under the group contract which 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 it is available for 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" refers to you, the person to whom this booklet is issued and whose name appears on the Identification Card, and to any members of your family who are also covered under this Plan.

4. **Medically Necessary.** We will not make payment under this Plan for any service, test, or treatment, if we determine, in our sole judgment, that the service or care was not Medically Necessary and appropriate in your particular case. This is true for In-Network Benefits as well as Out-Of Network Benefits.

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

   - consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury;
   - in accordance with standards of good medical practice;
   - not for your convenience or that of your physician or other provider;
   - the most appropriate supply, level of care, or service which can be safely provided to you; and
   - provided in the most appropriate setting for the treatment of your condition.

   For services rendered in a Skilled Care Facility, the care must be at a level that requires you to receive skilled care on a daily basis and hospitalization would otherwise be required and Medically Necessary. For Home Care services, the care must be at a skilled level and hospitalization or confinement in a Skilled Care Facility would otherwise be required and Medically Necessary.

Examples of medically unnecessary care include the following: when you are admitted to a Hospital for care which could have been provided in a Physician'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 Physician's office; when you are in a Hospital for longer than is necessary to treat your condition; when 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 or treat your condition; and/or when the services you receive are more costly than is necessary for the proper treatment of your condition.

In the above situations, we will determine, in our sole judgment, whether the service provided to you qualifies for payment under this Plan. In making our determination, we will examine the information supplied to us by your physician, Hospital or other provider of care. The fact that your physician or other provider prescribed the care does not automatically mean that the care qualifies for coverage under this Plan. If coverage is denied by us because we determine a service is not Medically Necessary, you may have the right to appeal as indicated in Sections Fifteen and Sixteen.

5. **Relationship Between Us And Preferred Providers.** The relationship between us and a Preferred Provider is an independent contractor relationship. Preferred Providers are not our employees or agents nor do we control the treatment or other professional activities of any Preferred Provider. Any of our determinations or determinations of our Medical Director only relate to whether we will make payment for services under this Plan and are not a substitute for the professional judgment of a Preferred Physician or Provider.

6. **Our Operating Area.** When we refer to Our Operating Area, we mean the Counties of Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington in the State of New York.

7. **Relationship Between Us And The BlueCross BlueShield Association.** HealthNow New York Inc. (HealthNow) doing business as BlueShield of Northeastern New York is an independent not-for-profit Health Services Corporation organized under the laws of New York State. HealthNow also operates under licenses with the BlueCross BlueShield Association, the association of independent BlueCross and BlueShield Plans which licenses HealthNow to use BlueCross BlueShield service marks in a portion of New York State. HealthNow does not act as an agent of the BlueCross BlueShield Association and is solely responsible for honoring its agreements to insure or administer its customers' health programs.

   BlueCard Program. All BlueCross and BlueShield Plans participate in a national program called the BlueCard Program. This national program benefits BlueCross and/or BlueShield members who receive covered services outside Our Operating Area.

   When you obtain health care services through the BlueCard Program outside Our Operating Area, the amount you pay for covered services is usually calculated on the lower of:

   - the actual billed charges for your covered services; or
   - the negotiated price that the local BlueCross and/or BlueShield Plan passes on to us.

   Often, the negotiated price will consist of a simple discount. However, sometimes the negotiated price is an estimated final price that factors in expected settlements or other non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be a discount from billed charges that reflects average expected savings. The estimated or average price may be prospectively adjusted in the future to correct for over or under estimation of past prices.

In addition, laws in a small number of states require BlueCross and/or BlueShield plans to use a basis for calculating your payment for covered services that do not reflect the entire savings realized, or expected to be realized, on a particular claim. When you receive covered health care services in those states, your required payment for these services will be calculated using their statutory methods.

8. **Waiting Periods.** No waiting periods for preexisting conditions apply to this Plan.

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, the following members of your family may also be covered:

   - your wife or husband, unless you are divorced or your marriage has been annulled;
   - your unmarried children who are under 19 years of age; your unmarried children who are older than the age dependent coverage would otherwise terminate and who are incapable of self-sustaining employment by reason of mental illness, developmental disability, or mental retardation, as defined in the New York State Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age at which dependent coverage would otherwise have terminated. The child's disability must be certified by a physician. In addition to this certification, we have the right to check whether a child is and continues to qualify as an incapacitated child; and
   - your unmarried children under the age of 25 who are enrolled as full-time students at an accredited institution of learning. Scheduled vacations at the school will not affect coverage. If a student covered under this provision is required to take a medical leave of absence from school due to illness, coverage for the student under this Plan will continue for up to one year beyond the last day of attendance in school or until the student's coverage would otherwise terminate under this Plan, whichever comes first. For coverage under this Plan to continue for a full-time student while on a medical leave of absence, a Physician licensed in the State of New York must certify to us in writing that the medical leave of absence from school is Medically Necessary Coverage will automatically terminate on the date the student reaches age 25, marries, or is no longer a full-time student, whichever occurs first.

2. **Other Children Who May Be Covered.** In addition to your natural children, the following other children may also be covered under this Plan if the child meets the above tests for children covered under this Plan:

   - a legally adopted child;
   - a child for whom you have been appointed the legal guardian by court order;
   - a stepchild dependent upon you; 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 becoming final.

3. **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 by Paragraph 7 below. In addition, if you have individual, two-person, 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 of Paragraph 7 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.

4. **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 Paragraph 7 below, we will cover a proposed adoptive newborn from the moment of birth if the following conditions are met:

   - you (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the Hospital after birth; and
   - you file a petition pursuant to §115-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 Paragraph 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 §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 adoption is revoked or one of the natural parents revokes their consent, we will be entitled to recover any sums paid by us for care of the adopted newborn.

5. **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 domestic partnership, for purposes of coverage under this Plan, consists of the characteristics set forth below.

   The partners must be:

   - 18 years of age or older;
   - residing together;
   - unmarried;
   - not related by marriage or blood in a way that would bar their marriage to each other; and
   - financially dependent upon each other.

   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.

   A. **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 in a form acceptable to us must be filed 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.** The partners 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 the partners are living together.

      3. **Proof Of Economic Interdependence.** At least two of the following must be provided to us:

- joint bank account;
- joint ownership or holding of investments;
- joint ownership/lease of a residence;
- joint credit cards or charge cards;
- joint ownership of a car;
- joint obligation on a loan;
- status as authorized signatory on the partner's bank account, credit card or charge card;
- joint ownership of real estate other than residence;
- listing of both partners as tenants on the lease of the shared residence;
- shared rental payments of residence (need not be shared 50/50);
- listing of both partners as tenants on a lease, or shard rental payments, for property other than residence;
- common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
- shared household budget for purposes of receiving government benefits;
- status of one as representative payee for the other's government benefits;
- joint ownership of major items of personal property (e.g., appliances, furniture);
- joint responsibility for child care (e.g., school documents, guardianship);
- shared child-care expenses. e.g., baby sitting, day care, school bills (need not be shared 50/50);
- designation as beneficiary under the other's life insurance policy;
- designation as beneficiary under the other's retirement benefits account;
- execution of wills naming each other as executor and/or beneficiary;
- mutual grant of Durable Powers of Attorney;
- mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- 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.

B. **Determination As To Eligibility Of A Domestic Partner.** The eligibility of your domestic partner under the 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.

C. **Domestic Partner's Children Are Excluded.** The children of your domestic partner are not eligible for coverage under this Plan unless:

- 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.

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

- Spousal Coverage - If spousal coverage applies, then only you, the member of the group whose name appears on the Identification Card, and your wife or husband as described above are covered.

- Two-Person Coverage - If two-person coverage applies, then only you, the member of the group whose name appears on the Identification Card, and either your wife or husband or domestic partner as described above or your one child as described above are covered.

- Child Coverage - If child coverage applies, then you, the member of the group whose name appears on the Identification Card, and your child or children as described above are covered.

- Family Coverage - If family coverage applies, then you, the member of the group whose name appears on the Identification Card, and your wife or husband or domestic partner and your children as described above are covered.

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 Paragraph 7 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 plan. 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.

7. **Notification Of Change In Your Coverage**.

A. **To Add A Spouse , Domestic Partner, Or Child.** If you need to add a spouse , domestic partner, or child to your coverage, you must complete and return to us a form for this purpose and any requested documentation. The addition of a spouse , domestic partner, or child will be effective as of the date of marriage, birth, or adoption , or other conditions entitling the individual to coverage according to our guidelines if you return to us a completed application and requested documents within 30 days of the event and the applicable premium is paid. If you do not return a completed form and documentation within 30 days, your spouse , domestic partner, or child will be added to your coverage as of the next premium due date after we receive the completed form and requested documentation, so long as the applicable premium is paid.

B. **When Coverage Of A Spouse , Domestic Partner, Or Child Terminates.** If you have other than individual coverage you should notify us of any event that affects your coverage, such as, your divorce, dissolution of domestic partnership, the death of your spouse, Medicare eligibility, or 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 they are received.

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

Section Three - Inpatient Care In-Network Benefits

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:

   - the Hospital is a Preferred Hospital. A "Preferred Hospital" is a Hospital, which has an agreement with us to provide In-Network services to persons covered under this Plan; your admission to the particular Preferred Hospital is authorized by a Preferred Physician and approved by us. We may require that you receive inpatient care in a particular Preferred Hospital depending upon the services you will require;
   - while in the Hospital you remain under the care of a Preferred Physician;
   - the Hospital is located in Our Operating Area; and
   - 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.

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 licensed 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** considered Acute Hospital Care:

   - 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 facility, whether or not such placement is available to you;
   - a Hospital stay or portion of a Hospital stay during which services you receive are primarily for diagnostic x-rays, laboratory tests, or other types of diagnostic studies, which could be performed in an outpatient setting; and
   - a Hospital stay or portion of a Hospital stay which is primarily for physical rehabilitation, except as indicated below.

   In the event a service is denied as non-acute care, you may have the right to the Utilization Review Procedures in Section Fifteen and External Review Procedures in Section Sixteen.

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 Preferred Hospital.** We will provide coverage for Acute Hospital Care, as defined above, in a facility, which is not a Preferred Hospital under the following conditions:

   - your medical condition is such that in the judgment of a Preferred Physician and subject to the approval of our Medical Director, you need to be hospitalized;

- in the judgment of a Preferred 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 Preferred Hospital;
- the facility is designated by a Preferred Physician and approved in advance of your care by our Medical Director; and
- care in the facility will be provided only for as long as you would otherwise have been confined in a Preferred Hospital.

We will provide coverage for an Emergency Condition in a Non-Preferred Hospital only for as long as our Medical Director determines that hospitalization was Medically Necessary and that your medical condition prevented your transfer to a Preferred Hospital.

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

- 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 Participating Hospital, you will have to pay the difference between what we pay and the Hospital's charge for the private room;**
- special diets;
- use of operating, recovery, and cystoscopic rooms and equipment;
- use of intensive care or special care units and equipment;
- 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;
- dressings and plaster casts;
- professional services, supplies, and use of equipment in connection with:

  (i) oxygen;
  (ii) physiotherapy; and
  (iii) laboratory and pathological examinations.

- use of equipment in connection with:

  (i) anesthesia;
  (ii) electrocardiograms;
  (iii) electroencephalograms;
  (iv) x-ray examinations;
  (v) diagnostic Imaging;
  (vi) radiation therapy; and
  (vii) chemotherapy.

6. **Services Not Covered.** The following services are not covered:

- private duty nurses; unless in the judgment of a Preferred Provider and our Medical Director, private duty nurses are Medically Necessary for your condition;
- private room, unless in the judgment of a Preferred Provider and our Medical Director, a private room is Medically Necessary for your condition;
- non-medical items including, but not limited to, television rental or telephone services;
- 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 service provided by the Preferred Hospital and included in their charge for the Hospital stay;
- medications, supplies, and equipment which you take home from the Hospital; and
- 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 Hospital Care.** We will provide coverage for care in a Preferred Hospital, or other Preferred Facility, under the conditions described above, for any day a Preferred Physician and our Medical Director determine that hospitalization was Medically Necessary for the care or treatment of your condition, illness, or injury, except for the limitation on the number of days of care for the treatment of mental, nervous, or emotional disorders or ailments, chemical abuse, physical therapy, and skilled facility care described below. We may designate a particular Hospital for your admission, depending upon the care or treatment you need. We will not pay for care after a date a Preferred Physician and/or our Medical Director determine that hospitalization was no longer Medically Necessary.

8. **Maternity And Newborn Inpatient Care.** Except for perinatal complications, we will provide coverage for inpatient maternity care in a Preferred 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.

   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 pursuant to Section 6951 of the Education Law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health 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 Seven. 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. This Home Care visit will not be subject to any deductibles or copayments.

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. The length of stay will be determined by you and your Preferred 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 under this Section and under Section Eleven for up to an aggregate of days of hospitalization in a calendar year for active treatment of mental, nervous, or emotional disorders or ailments. The hospitalization must be Medically Necessary in the judgment of a Preferred Provider 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 Hygiene.

11. **Chemical Abuse**. We will provide coverage under this Section and under Section Eleven for up to an aggregate of 7 days of inpatient hospitalization in a calendar year for Active Treatment for detoxification as a consequence of chemical dependence. "Chemical Dependence" shall mean and include alcoholism and substance dependence. "Active Treatment" means treatment given or ordered by a licensed professional furnished while you are an inpatient and which can only be rendered while you are an inpatient at a facility which is certified by the Office of Alcoholism and Substance Abuse Services.

12. **Admissions For Physical Rehabilitation.** We will provide coverage under this Section and under Section Eleven for up to an aggregate of 120 days of hospitalization in a calendar year, per person, for care which is primarily for restorative physical rehabilitation.

13. **Care In A Skilled Care Facility**. We will provide coverage for care in a Skilled Care Facility or a Skilled Care Facility located in a Hospital only if all of the following conditions are met:

- a Preferred Physician obtains the approval of our Medical Director before arranging for the care;
- a Preferred 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; and
- the Skilled Care Facility is a Preferred Skilled Care Facility or a Skilled Care Facility located in a Preferred Hospital A "Preferred Skilled Care Facility" and a “Preferred Hospital” are facilities which have an agreement with us to provide In-Network services to persons covered under this Plan.

  "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 under this Section and under Section Eleven for up to an aggregate of 365 days of skilled facility care per person, per calendar 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. However, we will not pay for custodial care. Custodial care is care which is primarily for the purpose of meeting personal needs and which could be provided by persons without professional skills or training. For example, custodial care includes, but is not limited to, activities of daily living such as help in transferring, bathing, dressing, eating, toileting, and other such related activities.

14. **Our Payments**. We will pay the following:

A. **Inpatient Hospital Care.** We will pay 100% of the amount the Hospital has agreed to accept from us as payment in full, 100% of the amount specified under state law, or 100% of charges, whichever is less, for covered services.

B. **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 or other provider is employed by the Hospital and charges for the services are billed by and retained by the Hospital.

Section Four - Outpatient Care In-Network Benefits

1. **Pre-Admission Testing.** We will also provide coverage for pre-admission testing provided on an outpatient basis in the Hospital prior to a scheduled inpatient surgery, if all of the conditions described above and the following conditions are met:

- they are related to, necessary for, and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;

- you have a reservation for the Hospital bed and for the operating room before the tests are given;
- you are physically present at the Hospital when the tests are given; and
- admission to the Hospital actually takes place within seven (7) days after the tests are given.

2. **Conditions For Coverage Of Outpatient Surgery.** We will provide coverage for outpatient surgery in a Preferred Hospital or in a Preferred Freestanding Ambulatory Care Center if a Preferred Physician and our Medical Director determine it is Medically Necessary for such surgery to be performed and the surgery cannot be performed in a physician's office, clinic, or less intensive setting. When you have Outpatient Surgery in a Hospital or Freestanding Ambulatory Care Center, you are entitled to the same services we would provide if you were an inpatient in a Preferred Hospital. As in the case of inpatient surgical care, a Preferred Physician or Provider must provide the services.

Section Five - Hospice Care In-Network Benefits

1. **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:

   - you have an illness for which a Preferred Physician's prognosis for life expectancy is estimated to be six months or less; and
   - palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.

2. **Hospice Organizations.** We will only provide coverage for Hospice Care provided by a Preferred Hospice. A "Preferred Hospice" is a hospice, which has an agreement with us to provide In-Network services to persons covered under this Plan. A Preferred Physician and our Medical Director must authorize the hospice services you receive and you must remain under the care of a Preferred Physician while receiving hospice services.

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

   - bed patient care, either in a designated hospice unit or in a regular Hospital bed;
   - day care services provided by the Hospice organization;
   - bereavement counseling services provided to the patient's family during illness and after the patient's death; and
   - home care and outpatient services which are provided by the Hospice and for which the Hospice charges you. The services may include the following:

     (i) intermittent nursing care by an RN, LPN or Home Health Aides;
     (ii) physical therapy;
     (iii) speech therapy;
     (iv) occupational therapy;
     (v) respiratory therapy;
     (vi) social services;
     (vii) nutritional services;
     (viii) laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms;
     (ix) medical supplies;
     (x) drugs and medications prescribed by a Preferred Physician and which are considered approved under the US Pharmacopoeia and/or National Formulary;
     (xi) Durable Medical Equipment; and

(xii) medical care provided by a Preferred Physician.

The services must be Medically Necessary and appropriate for the care of the patient and provided or arranged by the Hospice organization. All services must be billed by the Hospice organization.

4. **Number Of Visits**. We will provide coverage under this Section and Section Eleven for up to an aggregate of 210 days of hospice care per person per calendar year, beginning with the first day on which care is provided. We will also provide coverage under this Section and Section Eleven for up to an aggregate of five visits for bereavement counseling services to your family, either before or after the patient's death.

5. **Copayment.** Each person covered under this Group Plan is obligated to pay a $20 copayment each time the person receives Hospice services under this Section.

Section Six - Medical Services In-Network Benefits

1. **Medical Services While Hospitalized.** Except as limited by the provisions of Paragraph 3 below or the exclusions of Section Twelve, during any hospitalization covered under Section Three or outpatient surgery covered under Section Four, we will provide coverage for the services of a Preferred Physician or another Preferred Provider.

2. **Outpatient Care.** Except as limited by the provisions of Paragraph 3 below, Section Eight or the exclusions of Section Twelve, we will provide coverage for the same services provided to you in the outpatient department of a Preferred Hospital as we would provide if you were an inpatient. We will provide coverage for pre-admission tests for a hospitalization covered under Section Three. The services must be provided by a Preferred Physician or by another Preferred Provider. We will also provide coverage for mammography screenings, cervical cytology screenings, and prostate cancer screenings when provided in the outpatient department of a Preferred Hospital. The services must be provided by a Preferred Physician or Provider.

3. **Office Visits And Other Medical Services.** We will provide coverage for the following services by a Preferred Provider. Except as provided otherwise, the service must be provided in a Preferred Provider's Office. If your Preferred Physician or other Preferred Provider refers you to a physician or provider who is not a Preferred Provider, such referral must be approved in advance by our Medical Director in order to qualify for In-Network Benefits.

   A. **Preventive Health Services.** Subject to any other limitations in this Plan, we will provide coverage for physical examinations, family planning services, clinical laboratory and radiological tests, including mammography screenings, cervical cytology screenings (pap smears),diagnostic screening for prostate cancer, immunizations, and ear examinations.

   B. **Well Child Care.** We will provide coverage for the well child care benefits described below for covered children from the date of birth through the attainment of 19 years of age:

      - an initial newborn check-up in the Preferred Hospital and well child visits including a medical history, a complete physical examination, developmental assessment, anticipatory guidance and laboratory tests ordered at the time of the visit which are performed in the office or in a clinical laboratory. All well child visits must be provided in accordance with the prevailing clinical standards and frequency schedule of the American Academy of Pediatrics.

- necessary immunizations against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza type B and hepatitis B, prevnar, varicella, as well as any other immunizations specified by the American Academy of Pediatrics.

Coverage for these services shall be provided only to the extent that such services are provided by or under the supervision of a Preferred Physician or Other Preferred Provider licensed under Article 139 of the Education Law whose scope of practice pursuant to such law includes the authority to provide these services. The well child visits can be performed by the Preferred Physician or Other Preferred Provider in their office or in a Preferred Hospital.

We will not pay for these services if benefits have already been provided under Section Eleven during the same calendar year.

C. **Diagnosis And Treatment.** Except as otherwise limited by any other provisions of this Plan, we will provide coverage for the services of a Preferred Physician or by another Preferred Provider for the diagnosis and treatment of your disease, injury, or other condition. This includes surgical procedures, consultations, and visits. You must pay a $25 copayment for services provided at an urgent care center.

D. **X-Ray, Imaging And Laboratory Services.** We will provide coverage for x-rays, imaging, and laboratory tests and services provided by a Preferred Physician or Provider. This includes prescribed diagnostic x-rays and other imaging, x-ray therapy, and laboratory tests.

E. **Outpatient Or Office Rehabilitative Therapy.** We will provide coverage under this Paragraph and under Section Eleven for up to an aggregate of 120 visits per person, per calendar year for physical, occupational, and speech therapy when a Preferred Physician or Provider and our Medical Director determine that it is Medically Necessary.

F. **Outpatient Or Office Cardiac Rehabilitation Program.** We will provide coverage for a program of Phase II Cardiac Rehabilitation consisting of cardiac monitoring and the presence of a professional staff, if approved in advance by our Medical Director. We will provide coverage under this Paragraph and under Section Eleven for up to an aggregate of 24 visits per calendar year provided in a twelve-week period following an acute episode of a heart condition.

G. **Injectable Medications.** We will provide coverage for injectable medications which, in our sole judgment, must be administered by a Preferred Physician or Preferred Provider in the physician's or provider's office for preventive or therapeutic purposes. We will not pay for medications which, in our sole judgment, can be self-injected, whether or not they are administered by a Preferred Physician or Provider.

H. **Assistance At Surgery In A Hospital.** We will provide coverage for the services of a second Preferred Physician assisting another Preferred Physician who performs your operation if:

- the operation takes place in a Preferred Hospital where there is no house staff;
- the operation takes place in a Preferred Hospital where there is no Hospital resident in the specialty involved, certified or authorized, to assist at surgery;
- the complexity of the procedure is such that only a Physician could assist; and
- the assistance is in connection with a surgical operation or procedure, which is covered under this Section.

The copayment provision listed in Paragraph 4 does not apply to this benefit

I. **Anesthesia.** We will provide coverage for the administration of anesthesia in connection with surgery or maternity care covered under this Section if, in our sole judgment, the nature of the procedure requires anesthesia. We will not provide coverage for charges related to local anesthesia. We will provide coverage for anesthesia related to dental care or treatment in connection to 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

The copayment provision listed in Paragraph 4 does not apply to this benefit.

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

K. **Outpatient Treatment Of Mental, Nervous, Or Emotional Disorders Or Ailments.** We will provide coverage under this Paragraph and under Section Eleven for up to an aggregate of outpatient visits per person, per calendar year for the diagnosis and treatment of mental, nervous, or emotional disorders or ailments provided to you on an outpatient basis in a Preferred Physician's or Provider's office or by a Preferred 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 or in a Preferred facility operated by the New York State Department of Mental Hygiene. Under this Section, you must pay a $20 copayment for each visit.

L. **Outpatient Treatment Of Chemical Abuse And Chemical Dependence.** We will provide coverage for outpatient visits in a Preferred facility for the diagnosis and treatment of chemical dependence when, in our sole judgment, 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.

(i) **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.

(ii) **Number Of Visits.** We will provide coverage under this Section and Section Eleven for up to an aggregate of 60 outpatient visits per person, per calendar year for the treatment of alcoholism and substance dependence. Up to 20 of the 60 available visits may be used for family therapy by a family member who identifies himself/herself as a family member of a person suffering from the disease of alcoholism, substance abuse, or chemical dependency and who seeks treatment as a family member, who is otherwise covered by this Plan. Regardless of the number of covered family members, only 20 family visits are available in connection with the treatment of family members of a person suffering from the disease of alcoholism, substance abuse, or chemical dependence.

Family therapy consists of the visits described above which include members of your family in order for your family to understand your illness and play a meaningful role in your 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.

(iii) **Facilities Where We Will Pay For Treatment.** Coverage is limited to Preferred 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.

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.

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

- a Preferred Physician recommends that surgery be performed;
- the second surgical opinion is rendered by a Preferred Physician who is a board certified specialist and who, by reason of his specialty, is an appropriate physician to consider the proposed surgical procedure;
- 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; and
- the board certified specialist who renders the second surgical opinion does not also perform the surgery for which the second surgical opinion was obtained.

We will not provide coverage for a second surgical opinion under this Section if a second surgical opinion for the same condition has been covered under Section Eleven.

N. **Second Medical Opinions.** 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 recurrence of cancer. A positive diagnosis of cancer occurs when you are diagnosed by your Preferred Physician or Provider, as having some form of cancer. A negative diagnosis of cancer occurs when your Preferred Physician or Provider performs a cancer screening exam on you and then finds that you do not have cancer. We will also 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 specialist, including but not limited to, a specialist affiliated with a Specialty Care Center for the treatment of cancer. The specialist rendering the second medical opinion must be a Preferred Physician or Provider, unless you received an approved written referral from a Preferred Physician or Provider to a Non-Preferred specialist. If you receive an approved written referral to a Non-Preferred specialist, you will be required to pay the same copayment you would have paid if you received care from a Preferred Physician or Provider.

We will not provide coverage for a second medical opinion under this Section if a second medical opinion for the same condition has been covered under Section Eleven.

O. **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 also pay for reconstructive surgical procedures on the other breast to produce a symmetrical appearance. Coverage will be provided for all such services rendered in the manner determined appropriate by you and your Preferred Physician or Provider.

P. **Obstetrical Services.** We will provide coverage for services for the termination of a pregnancy by a delivery of a baby, by abortion, or by miscarriage. We will provide coverage for maternity care which includes payment for all the necessary care provided

by the Preferred Physician or Other Preferred Medical Professional which is related to the pregnancy including pre-natal, delivery and postpartum care.

You must pay a copayment for the first office visit related to maternity care.

We will also provide coverage for the following services from a Preferred Physician or Provider without prior authorization:

- up to two (2) annual examinations for primary and preventive obstetric and gynecologic care; and
- obstetric and gynecological care required as a result of such annual examinations or as a result of an acute gynecological condition.

We will not provide coverage for the annual examinations if benefits have been paid for under Section Eleven during the same calendar year.

Q. **Radiation Therapy ,Chemotherapy, And Hemodialysis.** We will provide coverage for radiation therapy, chemotherapy, and hemodialysis.

R. **Chiropractic Care.** Chiropractic Care is a covered service when it is:

- determined to be Medically Necessary;
- rendered by a Preferred 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.

S. **Mammography Screenings.** We will provide coverage for the Hospital and medical costs related to mammography screenings for occult breast cancer performed in a Preferred Hospital or a Preferred Physician's or Provider's office subject to the following aggregate limitations:

(i) **Women At Risk.** We will provide coverage for a mammogram for women of any age who have a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer if the mammogram is recommended by a physician.

(ii) **Women 35 Through 39 Years Of Age.** We will provide coverage for one baseline mammogram for women 35 through 39 years of age.

(iii) **Women 40 Years Of Age And Older.** We will provide coverage for one mammogram in each calendar year for women 40 years of age and older 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.

We will not provide coverage for mammography screenings under this Section if benefits have been covered under Section Eleven during the same calendar year.

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

women 18 years of age or older. The screening may be provided in the outpatient department of a Preferred Hospital or, in a Preferred Provider'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.

We will not provide coverage under this Section if benefits for a cervical cytology screening have been provided under Section Eleven during the same calendar year.

U. **Diagnostic Screening For Prostate Cancer.** We will provide coverage for the Hospital or medical costs related to diagnostic screening for prostatic 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:

- 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; and
- 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.

We will not provide coverage for the annual exam under this Section if benefits have been covered under Section Eleven during the same calendar year.

V. **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:

(i) 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.

(ii) When multiple surgical procedures are performed during the same operative session and through the same incision, we will cover the major procedure.

(iii) 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.

W. **Electrocardiographic Examinations (ECG).** We will provide coverage for two electrocardiograms (ECG) per calendar year rendered in the outpatient department of a Preferred Hospital or a Preferred Physician's office, if they are Medically Necessary for the diagnosis and treatment of your condition. We will not pay for ECG in connection with routine physical examinations. We will not provide coverage for benefits under this Section if these benefits have been covered under Section Eleven during the same calendar year.

X. **Electroencephalographic Examinations (EEG).** We will provide coverage for one electroencephalographic examination (EEG) per calendar year rendered in the outpatient department of a Preferred Hospital or a Preferred Physician's office, if it is Medically Necessary for the diagnosis and treatment of your condition. We will not provide

coverage for benefits under this Section if these benefits have been covered under Section Eleven during the same calendar year.

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:

(i) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
(ii) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
(iii) on a prescribed drug regimen posing a significant risk of osteo-porosis; or
(iv) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
(v) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

4. **Copayment.** Unless otherwise stated herein, each person covered under this Plan is obligated to pay a $20 copayment whenever any of the services described in Paragraphs 2 or 3 above are provided in an outpatient or office setting. This copayment is required when you receive services directly from a Preferred Physician or Provider. Copayments are not required when you receive well child care and well child immunizations x-ray, imaging, and laboratory services, hemodialysis, chemotherapy, or radiation therapy or as otherwise provided in this Plan. However, the copayments required under this Section will apply to any well child care visits provided which are in excess of the standards of the American Academy of Pediatrics.

5. **Durable Medical Equipment.** We will provide coverage for Durable Medical Equipment, which has been requested by a Preferred Physician and approved in advance by our Medical Director. We will provide coverage for the Durable Medical Equipment 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:

- is intended for repeated use (the type of item that could normally be rented);
- is not designed for a specific individual's use;
- is primarily and customarily used for a medical purpose as opposed to a comfort purpose;
- is not useful to a person in the absence of illness or injury; and
- 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 pay 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 prostheses, experimental or research equipment, and electronic communication devices. Also, we will not provide coverage for deluxe equipment (such as a motor driven wheelchair) when standard equipment is available and

medically adequate unless a Medical Necessity determination is rendered after the completion of the Utilization Review Process as described in Section Fifteen. 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 Sixteen.

We will only provide coverage for Durable Medical Equipment obtained from a supplier we designate as a Preferred Durable Medical Equipment Supplier. A Preferred Durable Medical Equipment Supplier is a Durable Medical Equipment Supplier who has a contract with us to provide In-Network benefits for Durable Medical Equipment to persons covered by this Plan.

6. **Post-Mastectomy Prosthetics.** We will provide coverage for post-mastectomy prosthetics which are directly related to the treatment of your condition. The post-mastectomy prosthetics must be requested by your Preferred Physician and approved by us.

   We will only provide coverage for post-mastectomy prosthetics which are obtained from a Preferred Supplier. A Preferred Supplier is a supplier who has a contract with us to provide In-Network benefits for post-mastectomy prosthetics to persons covered by this Plan.

7. **External Prosthetic And Orthotic Appliances.** We will provide coverage for external prosthetic and orthotic appliances which have been approved in advance by a Preferred Physician and our Medical Director, for as long as our Medical Director determines that they are Medically Necessary.

   The appliance must be an external prosthetic or orthotic device that is generally used for a medical purpose, as opposed to a comfort purpose. An external Prosthetic Appliance is an artificial substitute which replaces all or part of the function of a permanently inoperative, absent, or malfunctioning body part after surgical or accidental loss. An Orthotic Appliance is used to correct a defect of body form or function.

   Benefits are provided only for the basic prosthetic or orthotic appliances and any Medically Necessary special feature prescribed by your Preferred physician and approved by us.

   Appliances we will provide coverage for include post-mastectomy care including a prosthesis, artificial limbs or eyes, external cardiac pacemakers, stump socks, and rigid or semi-rigid supports, such as leg, arm, or back braces and trusses. The items we will not cover include orthotics used solely for sports, dentures or other teeth-related items, except for dental prosthetics required as a result of accidental injury to sound natural teeth if provided within 12 months of the accident and except for dental prosthetics necessary due to congenital disease or anomaly, hearing aids, eyeglasses or contact lenses, or non-rigid appliances and supplies, including but not limited to, elastic stockings, garter belts, arch supports, corrective shoes, wigs or hairpieces. We will also not cover items which we determine to be experimental or research devices or appliances. However, we may cover experimental or investigational devices or appliances if approved by an External Appeals Agent as described in Section Sixteen.

   We maintain a complete list of the external prosthetic and orthotic appliances we will cover. 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.

   We will only provide coverage for external prosthetic and orthotic appliances obtained from a supplier we designate as a Preferred Supplier. A Preferred Supplier is a supplier, which has

a contract with us to provide In-Network benefits for external prosthetic and orthotic appliances to persons covered by this Plan.

We will pay 80% of the amount the Preferred Supplier has agreed to accept as payment in full for the appliance. You must pay the remaining 20%.

8. **Alive & Lively 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 Preferred Providers designated by us. The topics, times, and frequency of the programs will be determined by us and our designated Preferred Providers. Certain programs are subject to a copayment. Consult your Provider Directory for information as to programs subject to a copayment and the amount of the applicable copayment.

Section Seven - Home Care In-Network Benefits

1. We will provide coverage for visits by a Preferred Home Health Care Agency licensed or certified under Article 36 of the New York State Public Health Law in your home if a Preferred Physician and our Medical Director determine that the visit is Medically Necessary. The visit may include the following:

   - part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (RN);
   - part-time or intermittent home health aide services which consist primarily of caring for the patient;
   - physical, occupational, or speech therapy if the Home Care Agency or Hospital provides these services;
   - medical supplies, drugs, and medications prescribed by a Preferred Physician, but only if we would have covered these items if you were in a Hospital or confined in a Skilled Care Facility; and
   - laboratory services provided by or on behalf of the Preferred Home Care Agency or Hospital.

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

   - 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; or
   - a plan for your Home Care is established and approved in writing by a Preferred Physician. A Preferred Physician must obtain approval from our Medical Director before arranging for visits in your home. 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. **Maternity Home Care Visit.** In the event a 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 Section Three, we will provide coverage for a Home Care visit. 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. This additional Home Care visit will not be subject to any limitation on the number of visits or to any deductibles, copayments, or coinsurance payments described in this Plan.

4. **Infusion Therapy.** We will provide coverage for Infusion Therapy provided to you 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-administered by injections into the muscle are not 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.

5. **Copayments.** Each person covered under this Plan is obligated to pay a $20 copayment each time the person receives Home Care services under this Section.

Section Eight - Emergency Care In-Network Benefits

1. **Emergency Room Care.** We will provide coverage for care rendered in the emergency room of a Preferred or Non-Preferred Hospital in cases of an Emergency Condition. You are not required to contact a Preferred Physician before obtaining care for an Emergency Condition. An "Emergency Condition" means a medical or behavioral condition that appears suddenly and is accompanied by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (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.

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

   We will not make any additional payment for follow-up care such as removal of sutures or check-up visits rendered in the emergency room.

2. **Limitation On Coverage For Care For An Emergency Condition In A Non-Preferred Hospital.** We will provide coverage for care in a Non-Preferred Hospital only for as long as our Medical Director determines that hospitalization was Medically Necessary and that your medical condition prevented your transfer to a Preferred Hospital.

3. **Copayments.** Each person covered under this Plan is obligated to pay a $50 copayment for each covered visit to the emergency room unless that person is admitted to the Hospital on that day as a registered bed patient as a result of the visit to the emergency room.

4. **Ambulance Service.** We will provide coverage for necessary prehospital emergency medical services, including prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. Our payment will be made only under the following conditions:

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

B. Evaluation and treatment services must be for an Emergency Condition defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(i) placing the health of the person afflicted with such condition in serious jeopardy;
(ii) serious impairment to such person's bodily functions;
(iii) serious dysfunction of any bodily organ or part of such person; or
(iv) serious disfigurement of such person.

C. Coverage for non-airborne emergency transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

(i) placing the health of the person afflicted with such condition in serious jeopardy;
(ii) serious impairment to such person's bodily functions;
(iii) serious dysfunction of any bodily organ or part of such person; or
(iv) serious disfigurement of such person.

D. The ambulance service was in connection with an inpatient admission or emergency outpatient care.

E. It was necessary that you were moved by ambulance to the hospital.

F. The ambulance was owned and/or operated by the Hospital or by a professional service.

G. We will not pay more than the regular charges for the ambulance service.

Section Nine - Treatment of Diabetes and Diabetes Self-Management Education In-Network Benefits

1. **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 when prescribed for your use outside of a Hospital, nursing home, physician's office or other institution. The prescription order must be issued by a Preferred Physician or Provider who is legally authorized to issue the prescription under Title Eight of the New York State Education Law. The prescription order must be filled by a licensed pharmacist in a retail pharmacy licensed by the State.

   The amount of our payment under this Plan depends on whether the prescription is filled at a Preferred Diabetic Drug Provider or at a Non-Preferred Diabetic Drug Provider.

   A. **Preferred Diabetic Drug Provider.** A "Preferred Diabetic Drug Provider" is a pharmacy which has entered into an agreement to provide covered In-Network diabetic drug benefits to the persons covered by this Plan and has an agreement for the payment of covered diabetic drugs. Call us for a list of Preferred Diabetic Drug Providers. This list may change from time to time. When you have a covered prescription filled at a Preferred Diabetic Drug Provider, you must pay the pharmacy a copayment for each separate prescription or refill. The Preferred Diabetic Drug Provider will be paid directly for the remainder of the amount it has agreed to accept for the prescription or refill.

   B. **Non-Preferred Diabetic Drug Provider Within Our Operating Area.** A "Non-Preferred Diabetic Drug Provider" is a pharmacy, which has not entered into an agreement for the

payment of covered In-Network diabetic drugs under this Plan. We will not make any payment for diabetic drugs or refills filled at a pharmacy which is not a Preferred Diabetic Drug Provider within our operating area (See Section One, Paragraph 6).

C. **Non Preferred Diabetic Drug Provide Outside Our Operating Area.** If your prescription is filled by a pharmacy located outside our operating area (See Section One, Paragraph 6) which is not a Preferred Diabetic Drug Provider, 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 Preferred Diabetic Drug Providers for that diabetic drug, as determined, in our sole judgment. If the pharmacy's charge is greater than the reasonable charge, we will not pay any part of the excess amount.

If you are also covered under a Prescription Drug Contract or Rider issued by us which covers the above items, you can elect to have your insulin, glucagon, or prescription oral agents for controlling blood sugar covered either under your Prescription Drug Contract or Rider or this Plan, whichever has the lower copayment.

2. **Diabetic Equipment And Supplies.** We will provide coverage for the following equipment and supplies for the treatment of diabetes when they are prescribed or recommended by a Preferred Physician or Provider legally authorized to prescribe under Title Eight of the New York State Education law and they are Medically Necessary:

- blood glucose monitors;
- blood glucose monitor for the visually impaired;
- data management systems;
- non-prescription oral agents for controlling blood sugar;
- test strips for glucose monitors, visual reading, and urine testing;
- injection aids;
- cartridges for the visually impaired;
- insulin pumps and pump accessories;
- insulin infusion devices; and
- 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 of 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.

We will only provide coverage for diabetic equipment and supplies obtained from a supplier we designate as a Preferred Diabetic Equipment or Supply Provider. A Preferred Diabetic Equipment or Supply Provider is a diabetic equipment or supply provider which has a contract with us to provide In-Network benefits for diabetic equipment or supplies to persons covered by this Plan.

3. **Diabetes Self-Management Education.**

A. **Alive & Lively Health Education And Wellness Programs.** The Alive & Lively 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. There

are no copayments for diabetes self-management programs through our Alive & Lively Health Education and Wellness Program.

We will provide coverage for certain 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.

Coverage for self-management education and education relating to diet shall be limited to visits which are Medically Necessary. Coverage will be provided, upon the diagnosis of diabetes, where a Physician diagnoses a significant change in your conditions or symptoms requiring a change in self-management, or where we determine that re-education or refresher education is necessary.

We will provide coverage for such education provided during an office visit by a Preferred Physician, Preferred Provider, or their staff legally authorized to prescribe under Title Eight of the Education Law. 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 include payment for the education.

We will also provide coverage for such education when it is provided by a certified diabetes nurse educator, certified nutritionist, certified dietician, or registered dietician upon referral of a Preferred Physician We will only provide coverage by these providers when the service is rendered in a group setting, when practicable. Please contact us if you need assistance arranging for group education.

We will also cover education provided in your home when it is Medically Necessary for you to receive such education at home.

4. **Copayment.** Each person is obligated to pay a $20 copayment whenever any of the services discussed above are received.

Section Ten - Infertility In-Network Benefits

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 and ultrasound.

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

Section Eleven - Out-of-Network Benefits

Coverage will be provided for the benefits described below when you elect to receive Out-Of-Network Benefits. Out-Of-Network benefits consist of care which is not provided by a Preferred Provider, and which is not emergency care covered under Section Eight of this Plan. These benefits will be covered subject to the deductible, copayments, annual maximum, dollar limitations, and other terms and conditions described below.

Whenever reference is made in this Section to a provider as Participating, we mean that the provider has an agreement regarding payment for covered Out-Of-Network benefits under this Section. The fact that a provider is a Preferred Provider, for In-Network benefits under Sections Three through Ten of this Plan does not mean that the provider is a Participating Provider for Out-Of-Network benefits listed in this Section. A "Non-Participating Provider" is a provider that does not have an agreement with us regarding payment for covered services under this Section.

We will not provide coverage for Out-Of-Network Benefits for any service or care which we determine, in our sole judgment, is not Medically Necessary as defined in Section One. The fact that your Physician prescribed the care does not automatically mean that the care qualifies for payments under this Plan.

1. **Inpatient Hospital Care.** We will only provide coverage for Acute Hospital Care as defined in Section Three. We will provide benefits when you are a registered bed patient in a Hospital as defined in Section Three. All services must be rendered by an employee of the Hospital, and the Hospital must bill for the services and retain the money collected from the service.

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

   - 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 Participating Hospital, you will have to pay the difference between what we pay and the Hospital's charge for the private room;**
   - special diets;
   - use of operating, recovery, and cystoscopic rooms and equipment;
   - use of intensive care or special care units and equipment;
   - 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;
   - dressings and plaster casts;
   - professional services, supplies, and use of equipment in connection with:

     (i) oxygen;
     (ii) physiotherapy; and
     (iii) laboratory and pathological examinations.

   - use of equipment in connection with:

     (i) anesthesia;
     (ii) electrocardiograms;
     (iii) electroencephalograms;
     (iv) x-ray examinations;
     (v) diagnostic Imaging;
     (vi) radiation therapy; and
     (vii) chemotherapy.

   - 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;
   - any additional medical services and supplies which are provided while you are a registered bed patient and which are billed by the Hospital; and

- 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.

B. **Services Not Covered.** The following services are not covered:

- private duty nurses;
- medications, supplies, and equipment which you take home from the Hospital; and
- non-medical items, such as television rental or telephone services.

C. **Number Of Days Covered.** Except for the limitation for inpatient care for mental, nervous, and emotional disorders, and inpatient physical rehabilitation, we will provide coverage for the first 365 days of Acute Hospital Care in each "Continuous Hospital Confinement" if we determine, in our sole judgment, that it is Medically Necessary for you to be an inpatient in a Hospital. A "Continuous Hospital Confinement" means an inpatient admission or series of inpatient admissions to one or more Hospitals, Skilled Care Facilities, or similar institutions which are not separated by more than 90 days.

A confinement for an accident will not be combined with another confinement for an illness when determining Continuous Hospital Confinement if the stay for the accidental injury is not related to any other illness or injury.

In determining how many days of Hospital care you have used, the day you are admitted to the Hospital will be counted as one day, but the day you are discharged will not be counted. If you are admitted and discharged the same day, one day will be counted.

D. **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 under this Section and Section Three for up to an aggregate of days of hospitalization in each calendar year per person for Active Treatment of mental, nervous, or emotional disorders or ailments"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 Hygiene.

E. **Chemical Abuse.** We will provide coverage under this Section and under Section Three for up to an aggregate of 7 days of inpatient hospitalization in a calendar year for Active Treatment for detoxification as a consequence of chemical dependence. "Chemical Dependence" shall mean and include alcoholism and substance dependence. "Active Treatment" means treatment given or ordered by licensed professional furnished while you are an inpatient and which can only be rendered while you are an inpatient at a facility which is a certified by the Office of Alcoholism and Substance Abuse Services.

Coverage is limited to facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services.

F. **Physical Rehabilitation.** We will provide coverage under this Section and under Section Three for a maximum aggregate of 120 days of hospitalization in a calendar year, per person, for care which is primarily for restorative physical rehabilitation.

G. **Maternity and Newborn Inpatient Care.** Except for perinatal complications, we will provide coverage for 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.

Maternity care shall include services of a midwife licensed pursuant to Article 140 of the New York Education Law, practicing consistent with a written agreement pursuant to Section 6951 of the Education Law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. However, we will not pay for duplicate 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 Seven. 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. This home care visit will not be subject to any deductibles or copayments.

H. **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. The length of stay will be determined by you and your physician.

2. **Care In A Skilled Care Facility.** After the annual Out-Of-Network deductible is satisfied, we will provide coverage for your care in a Skilled Care Facility when your physician refers you to the Skilled Care Facility prior to the time you enter the facility. Care must be at a level that we determine, in our sole judgment, requires that you receive skilled care on a daily basis and that hospitalization would otherwise be Medically Necessary We will not pay for any days of care in a Skilled Care Facility when, in our sole judgment, your condition did not require skilled care on a continuing basis. If you have any questions as to your eligibility for this benefit, we encourage you to call us.

   "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 not pay for custodial care. Custodial Care is care which is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes, but is not limited to, activities of daily living such as help in transferring, bathing, dressing, eating, toileting, and other such related activities.

   Skilled Care Facility benefits under this provision and under Section Three are limited to an aggregate of not more than 365 days of care per person per calendar year.

3. **Outpatient Hospital Care.** We will provide coverage for the care described below when it is provided in an outpatient department of a Hospital. As in the case of inpatient care, the service must be given by an employee of the Hospital, the Hospital must bill for the service and the Hospital must retain the money collected for service.

   A. **Outpatient Surgery.** After the annual Out-Of-Network deductible is satisfied, we will provide coverage for outpatient surgery in a Hospital or in a Freestanding Ambulatory Care Center certified under the Public Health Law of the State of New York if 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 it cannot be performed in a physician's office, clinic, or less intensive setting. However, we will not make any

additional payment for any follow-up care such as removal of sutures or check-up visits rendered in the Hospital. If the Freestanding Ambulatory Care Center is located outside New York State, the facility must have the approval of a comparable state authority as a Freestanding Ambulatory Surgical Center.

B. **Emergency Room Care.** We will provide coverage for care provided in the emergency room of a Hospital in case of an Emergency. You are not required to contact your Physician or other provider before obtaining care for an Emergency Condition. An "Emergency Condition" means a medical or behavioral condition that appears suddenly and is accompanied by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part or (4) serious disfigurement of such person.

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

We will **not** make any additional payment for follow-up care such as removal of sutures or check-up visits rendered in the emergency room.

You must pay a $50 copayment for each covered visit to the emergency room unless you are admitted to the Hospital on that day as a registered bed patient as a result of your visit to the emergency room.

C. **Pre-Admission Testing.** We will also provide coverage for pre-admission testing provided on an outpatient basis in the Hospital prior to a scheduled inpatient surgery, if all of the conditions described above and the following conditions are met:

- they are related to, necessary for, and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;
- you have a reservation for the Hospital bed and for the operating room before the tests are given;
- you are physically present at the Hospital when the tests are given; and
- admission to the Hospital actually takes place within seven (7) days after the tests are given.

4. **Outpatient Treatment For Chemical Abuse And Chemical Dependence.**

A. **Chemical Abuse And Chemical Dependence.** Chemical abuse shall mean and include alcohol and substance abuse. Chemical dependence shall mean and include alcoholism and substance dependence.

B. **Outpatient Visits.** After the annual Out-Of-Network deductible is satisfied we will provide coverage for outpatient visits in a facility described below for the diagnosis and treatment of chemical dependence when, in our sole judgement, 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.

C. **Number Of Visits.** We will provide coverage for up to 60 outpatient visits in each calendar year in the aggregate for the treatment of alcoholism and substance dependence for each person covered under this Plan. Up to 20 of the 60 available visits may be used for family therapy by a family member who identifies himself/herself as a family member of a person suffering from the disease of alcoholism, substance abuse, or chemical dependency and who seeks treatment as a family member who is otherwise covered by this Plan. Regardless of the number of covered family members, only 20 family visits are available in connection with the treatment of family members of a person suffering from the disease of alcoholism, substance abuse or chemical dependence.

Family therapy consists of the visits described above, which include members of your family in order for your family to understand your illness and play a meaningful role in your 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.

D. **Facilities Where We Will Pay For Treatment.** Coverage is limited to facilities in New York State 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 and, in other states, to those which are accredited by the Joint Commission on Accreditation of Hospitals as alcoholism or chemical dependence, and substance abuse 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.

We will reduce the number of visits available for this benefit by the number of visits for outpatient treatment of chemical abuse and chemical dependence which have been provided under Section Six during the same calendar year.

5. **Hospice Care**.

A. **Type Of Provider.** "Hospice Care" is care provided to terminally ill patients. After the annual Out-Of-Network deductible is satisfied, 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. If the Hospice Care is provided outside of New York State, the Hospice organization must have an operating certificate issued under standards, in our sole judgment, similar to those used in New York by a state agency in the state where the Hospice Care is provided.

B. **Eligibility For Benefits.** To obtain benefits for Hospice Care under this Plan, you must meet both of the following conditions:

- you must experience an illness for which the attending physician’s prognosis for life expectancy is estimated to be six months or less; and
- palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.

C. **Hospice Care Benefits.** We will provide coverage for the following services when provided by the Hospice organization:

- bed patient care either in a designated Hospice unit or in a regular Hospital bed;
- day care services provided by the Hospice organization;
- bereavement counseling services provided to the patient's family during illness and after the patient's death; and
- home care and outpatient services, which are provided by the Hospice and for which the Hospice charges you. The services may include the following:

  (i) intermittent nursing care by an RN, LPN or Home Health Aides;
  (ii) physical therapy;
  (iii) speech therapy;
  (iv) occupational therapy;
  (v) respiratory therapy;
  (vi) social services;
  (vii) nutritional services;
  (viii) laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms;
  (ix) medical supplies;
  (x) drugs and medications prescribed by a physician and which are considered approved under the US Pharmacopoeia and/or National Formulary;
  (xi) Durable Medical Equipment; and
  (xii) medical care provided by the Hospice physician.

  The service must be Medically Necessary and appropriate for the care of the patient, and provided or arranged by the Hospice organization. All services must be billed by the Hospice organization.

D. **Limitations On Amount Of Hospice Care.** We will provide coverage for up to 210 days of Hospice benefits described above beginning with the first day on which care is provided. We will provide coverage for up to five visits for bereavement counseling services.

   We will reduce the number of days of hospice care and the number of visits for bereavement counseling available under this Section by the number of days of Hospice care or bereavement counseling visits for which benefits have been provided under Section Five of this Plan during the same calendar year.

6. **Home Care.**

A. **Type Of Home Care Agency.** After the annual Out-Of-Network deductible is satisfied, we will pay for home care visits and infusion therapy given by a Home Care Agency certified or licensed under Article 36 of the New York State Public Health Law. If you receive home care outside of New York State, the care must be provided by a Home Care Agency or Hospital and the agency or Hospital must have Medicare approval and have an appropriate operating certificate to provide home care issued by the appropriate state agency.

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

- If you did not receive Home Care visits you would have to be hospitalized in a Hospital and receive Acute Hospital Care or cared for 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 Care or skilled nursing or skilled rehabilitative care.
- 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.

C. **Home Care Services Covered.** We will provide coverage for the following Home Care services provided by the Home Care Agency or Hospital, if you meet the conditions in Paragraph "B" above:

- part-time or intermittent home nursing care by or under the supervision of a registered nurse (RN).
- part-time or intermittent home health aide services which consist primarily of caring for the patient.
- physical, occupational, or speech therapy if the Home Care Agency or Hospital provides these services.
- medical supplies, drugs, and medications prescribed by a Physician, but only if we would have paid for these items if you were in a Hospital or confined in a skilled nursing facility.
- laboratory services provided by or on behalf of the Home Care Agency or Hospital.

D. **Maternity Home Care Visits.** 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 above, we will provide coverage for a home care visit. This additional home care visit will not be counted against the visit limit for home care visits in Paragraph "F" below. This home care visit will not be subject to any deductibles, copayments or coinsurance payments.

E. **Infusion Therapy.** We will provide coverage for Infusion Therapy provided to you 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-administered by injections into the muscle 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 Infusion Therapy.

F. **Number Of Home Care Visits.** We will provide coverage for Home Care visits and the other services listed above only for as long as you would otherwise have had to be hospitalized in a Hospital or confined in a Skilled Care Facility, but we will not pay for more than visits in each calendar 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.

We will reduce the number of Home Care and related services available under this Section by the number of Home Care and related services which have been covered under Section Seven during the same calendar year.

7. **Durable Medical Equipment.** After the annual Out-Of-Network deductible is satisfied, we will provide coverage for 70% of the lesser of our charges or the amount listed in the Schedule of Allowances we use with this Plan for Durable Medical Equipment. The item must be prescribed by your physician and directly related to the treatment of the condition. We will determine whether the item should be purchased or rented. You must pay the difference, if any, between the charge and our payment.

Durable Medical Equipment means equipment that:

- is intended for repeated use (the type of item that could normally be rented);
- is not designed for a specific individual’s use;
- is primarily and customarily used for a medical purpose as opposed to a comfort purpose;

- is not useful to a person in the absence of illness or injury; and
- is used at your home.

The items we will pay 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 pay for include, but are not limited to items not medical in nature, disposable supplies, hygiene equipment, sauna baths, air conditioners, humidifiers and dehumidifiers, wigs, hair prosthesis, experimental or research equipment, electronic communication devices, and exercise equipment. Also, we will not provide coverage for deluxe equipment (such as a motor driven wheelchair) when standard equipment is available and medically adequate unless a Medical Necessity determination is rendered after the completion of the Utilization Review Process as described in Section Fifteen. Notwithstanding the provisions of this paragraph, we may provide coverage for experimental or research equipment if approved by an External Appeal Agent as described in Section Sixteen.

8. **Post-Mastectomy Prosthetics.** After the annual Out-Of-Network deductible is satisfied, we will pay the lesser of the charges or amount listed in the Schedule of Allowances we use for this Plan for post-mastectomy prosthetics which are directly related to the treatment of your condition. You must pay the difference, if any, between the charge and our payment.

9. **Conditions of Coverage for Medical/Professional Services.** Except as otherwise provided, we will provide coverage for the services listed in Paragraph 10 of this Section only if all of the following conditions are met:

   - other than laboratory tests by an independent laboratory and certain services provided in connection with the treatment of diabetes, the services are performed by one of the following:

     (i) **Physician.** Under this Plan, a Physician is a licensed physician; osteopath; dentist or podiatrist.
     (ii) **Other Medical Professionals.** Except where it is specified that a service must be provided by a Physician, the service may also be performed by Other Medical Professionals. Under this Plan, Other Medical Professionals are a licensed physical therapist, licensed occupational therapist, speech therapist, licensed speech language pathologist or audiologist, optometrist, psychiatrist, certified and registered psychologist, psychiatric social worker who is certified under Article 154 of the New York State Education Law and who has completed at least six years of post-degree experience in psychotherapy that meets the requirements of the New York State Board for Social Work, a nurse-midwife licensed pursuant to Article 140 of the New York Education Law, a certified nurse anesthetist, a physician's assistant or a nurse practitioner, as defined in the New York Education or Public Health Laws. If you receive care covered under this Plan from Other Medical Professionals outside of New York State, such Other Medical Professionals must be licensed or certified under standards, in our sole judgment, similar to those used in New York State by a state agency in the state where the care is provided. All Other Medical Professionals must practice only within the scope of their license or certification. A certified nurse anesthetist, a physician's assistant or a nurse practitioner must practice under qualified medical direction and must be employed by and practice with a Physician.

   - the Physician or Other Medical Professional regularly bills for the services performed;
   - the bill is payable to the Physician or Other Medical Professional who performs the services. In other words, the payment of the bill is not made to, or turned over to, a

Hospital or other institution. The Physician or Other Medical Professional must retain the payment; and

- except in the case of well child care, mammography screenings, cervical cytology screenings, and prostatic cancer screenings described below, the services of the Physician or Other Medical Professional must be performed in connection with the diagnosis or treatment of your condition, disease, or ailment and must, in our sole judgment, be Medically Necessary for your diagnosis and treatment.

To be entitled to payment for some of the services described below, you must either be a registered bed patient in a Hospital or receive the services in the outpatient department of a Hospital.

10. **Medical/Professional Benefits Provided.** After the annual Out-Of-Network deductible has been satisfied, we will provide coverage for the following medical/professional services:

A. **Visits In A Hospital.** We will provide coverage for visits by a Physician 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 Physician or Other Medical Professional. The amount of payment for surgery or maternity care includes payment for visits. If one Physician or Other Medical Professional is treating for a separate and distinct condition, we will provide coverage for one visit per day by the other Physician 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 pay for more than one visit per day, regardless of whether such visits are by a Physician or Other Medical Professional Payment will be made for only one visit per day unless you are entitled to payment for care described in Subparagraph B below.

Payment for visits in a Hospital will be made only during the first 365 days of each Continuous Hospital Confinement. A "Continuous Hospital Confinement" means an inpatient admission or series of inpatient admissions to one or more Hospitals, Skilled Care Facilities, or similar institutions which are not separated by more than 90 days. A confinement for an accident will not be combined with another confinement for an illness when determining Continuous Hospital Confinement if the stay for the accidental injury is not related to any other illness or injury.

B. **Care In A Hospital.** We will only provide coverage for care by a Physician 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 Physician. We will determine, in our sole judgment, if such constant bedside attendance was necessary. We will pay for this care on any day you would be entitled to payment for a visit in the Hospital as described above. However, 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.

C. **Consultations In A Hospital.** We will provide coverage for a consultation only by a Physician if:

(i) the consultation was, in our sole judgment, required by your illness;
(ii) the consultation took place while you were a registered bed patient in a Hospital;
(iii) the consultant did not give you care or treat you after he or she consulted with your Physician;
(iv) the consultant entered a written report in your Hospital record; and

(v) the consultant meets the definition of a Physician 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 Physicians or Other Medical Professionals. However, if in our sole judgment, 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.

D. **Office Visits.** Except as otherwise limited or excluded, we will pay for Medically Necessary visits to the office of a Physician or Other Medical Professional.

E. **Outpatient Mental, Nervous, Or Emotional Disorders Or Ailments.** We will provide coverage for outpatient visits for mental, nervous, or emotional care provided to you on an outpatient basis by a facility issued an operating certificate by the New York State Commissioner of Mental Health pursuant to Article 31 of the New York State Mental Hygiene Law or in a facility operated by the New York State Office of Mental Hygiene. We will provide coverage for Physician and Other Medical Professionals services for the diagnosis and treatment of mental, nervous, or emotional care when the care is provided in a Physician's or Other Medical Professional's office. Our coverage is limited to an aggregate of outpatient mental health visits per calendar year. However, after the annual deductible is satisfied, our payment will be limited to 50% of the amount listed on our Schedule of Allowances for each such visit, instead of the 70% payment which applies to most of the other services covered under this Section. You must pay the difference between what we pay and the provider's charge for the service.

We will reduce the number of visits available under this Section by the number of outpatient mental health visits, which have been covered under Section Six of this Plan during the same calendar year.

F. **Rehabilitative Therapy.** We will provide coverage for up to an aggregate of 120 visits per person, per calendar year, for physical, occupational and speech therapy on an outpatient basis when we determine, in our sole judgment, that it is Medically Necessary treatment for your illness or injury. We will reduce the number of rehabilitative therapy visits available under this Section by the number of outpatient rehabilitative therapy visits that have been covered under Section Six of this Plan during the same calendar year.

G. **Cardiac Rehabilitation Program.** We will provide coverage for a program of Phase II Cardiac Rehabilitation consisting of cardiac monitoring and the presence of a professional following an acute episode of a heart condition. Our coverage is limited to 24 visits per calendar year provided in a twelve-week period following an acute episode of a heart condition if Medically Necessary for the treatment of your condition. We will reduce the number of cardiac rehabilitative visits available under this Section by the number of outpatient cardiac rehabilitative therapy benefits that have been covered under Section Six during the same calendar year.

H. **Radiology And Other Imagery.** We will pay for diagnostic x-ray, other imagery or radiation or radioactive material.

(i) **Provider Requirements.** We will provide coverage for radiology and other imagery procedures only if they are performed by a Provider in a Hospital and the installation of the equipment required for the radiology or other imagery procedure has been approved as required by law. If the radiology or other imagery procedure is performed in New York State, the installation of equipment must have been approved under the

New York State Public Health Law. If it is performed outside New York State, the installation of the equipment must have the approval of a comparable state authority.

If the radiology or other imagery procedure is performed other than in a Hospital, such as a Physician's office, clinic, or similar location, we will provide coverage for the radiology or other imagery procedure only if the New York State Public Health Law provides an approval procedure for such a location and only if the installation of the equipment where you receive the service has been approved under that procedure.

(ii) **Coverage Requirements.** 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 Physician 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 films, 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).

(iii) **Special Provisions Relating To MRI.** Except for emergency situations, we will only provide coverage for services relating to Magnetic Resonance Imaging (MRI) provided in Our Operating Area if performed by a Participating Physician and the MRI is provided either in the Physician's office, Hospital, or facility designated by us. We maintain a list of designated facilities. Please contact us if you would like a copy of that list.

I. **Maternity Care.** We will provide coverage for services for the termination of a pregnancy by a delivery of a baby, by abortion, or by miscarriage. We will provide coverage for maternity care which includes payments for all the necessary prenatal care and payment for delivery and postnatal care provided by the Physician or Other Medical Professional.

J. **Electrocardiographic Examinations (ECG).** We will provide coverage for two electrocardiograms (ECG) per calendar year rendered in the outpatient department of a Hospital or a Physician's office, if they are Medically Necessary for the diagnosis and treatment of your condition. We will not pay for ECG in connection with routine physical examinations. We will reduce the number of ECGs available under this Section by the number of ECGs that have been covered under Section Six during the same calendar year.

K. **Electroencephalographic Examinations (EEG.)** We will provide coverage for one electroencephalographic examination (EEG) per calendar year rendered in the outpatient department of a Hospital or a Physician's office, if it is Medically Necessary for the diagnosis and treatment of your condition. We will reduce the number of EEGs available under this Section by the number of EEGs that have been covered under Section Six during the same calendar year.

L. **Diabetes Equipment, Supplies And Education.**

1. **Insulin, Glucagon And Prescription Oral Agent For Controlling Blood Sugar.** We will provide coverage for insulin, glucagon, and prescription oral agents for controlling blood sugar when prescribed or recommended for your use outside of a Hospital,

nursing home, Physician's office, or other institution. The prescription order must be issued by a Physician or Other Medical Professional who is legally authorized to issue the prescription under Title Eight of the New York State Education Law. The prescription order or recommendation must be filled by a licensed pharmacist in a retail pharmacy licensed by the state in which the pharmacy is located. You must pay the pharmacy and submit a claim form and receipt to us which verifies that the prescription or recommendation was filled.

If you are also covered by a Prescription Drug Plan or Rider issued by BlueShield of Northeastern New York which covers those items, you can elect to have your insulin, glucagon, or prescription oral agents for controlling blood sugar covered under either your Prescription Drug Rider or this Plan, whichever has the lower copayment.

2. **Diabetic Equipment And Supplies**. We will provide coverage for the following equipment and supplies for the treatment of diabetes when they are prescribed or recommended by a Physician or Other Medical Professional legally authorized to prescribe under Title Eight of the New York State Education Law and we determine, in our sole judgment, that they are Medically Necessary:

   - blood glucose monitors;
   - blood glucose monitor for the visually impaired;
   - data management systems;
   - non-prescription oral agents for controlling blood sugar;
   - test strips for glucose monitors, visual reading and urine testing;
   - injection aids;
   - cartridges for the visually impaired;
   - insulin pumps and pump accessories;
   - insulin infusion devices; and
   - syringes and needles used in diabetic management.

   We will also provide coverage for such additional diabetes equipment and supplies as the New York State 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.

3. **Diabetes Self-Management Education.** We will provide coverage for certain 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.

   Coverage for self-management education and education relating to diet shall be limited to visits which are Medically Necessary. Coverage will be provided, upon the diagnosis of diabetes, where a physician diagnoses a significant change in your conditions or symptoms requiring a change in self-management, or where we determine that re-education or refresher education is necessary.

   We will provide coverage for such education provided during an office visit by a Physician or other licensed health care provider legally authorized to prescribe under Title Eight of the Education Law, 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 include payment for the education.

We will also provide coverage for such education when it is provided by a certified diabetes nurse educator, certified nutritionist, certified dietician, or registered dietician, upon referral of a physician. We will only provide coverage by these providers when the service is rendered in a group setting, when practicable. Please contact us if you need assistance arranging for group education.

We will also cover education provided in your home when it is Medically Necessary for you to receive such education at home.

M. **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:

(i) 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.
(ii) When multiple surgical procedures are performed during the same operative session and through the same incision, we will cover the major procedure.
(iii) 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.

N. **Assistance At Surgery In A Hospital.** We will provide coverage for the services of another Physician assisting the Physician who performs the operation if:

- the operation takes place in a Hospital where there is no house staff;
- the operation takes place in a Hospital where there is no Hospital resident in the specialty involved;
- the complexity of the procedure is such that only a Physician could assist;
- the assistance is in connection with a surgical operation or procedure, which is covered under this Section; or
- the other Physician is in the private practice of medicine and meets the conditions listed above.

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

- the second surgical opinion is rendered following a recommendation by your surgeon that surgery be performed. We will not provide coverage for a second surgical opinion when your family physician or internist makes the recommendation for surgery;
- the second surgical opinion is rendered by a Physician who is a board certified specialist and who by reason of his or her specialty is an appropriate Physician to consider the surgical procedure being proposed;
- the second surgical opinion is rendered with respect to an inpatient Hospital or outpatient Hospital surgical procedure of a non-emergency nature, which is covered under this Plan; and
- the board-certified specialist who renders the second surgical opinion does not also perform the surgery for which the second surgical opinion was obtained.

We will not provide coverage for a second surgical opinion under this Section if a second surgical opinion for the same condition has been covered under Section Six.

P. **Anesthesia.** We will provide coverage for the administration of anesthesia in connection with surgery or maternity care covered under this Plan if, in our sole judgment, the nature of the procedure requires anesthesia. If the Physician who administers the anesthesia also performs the surgery or gives the maternity care or also assists the Physician who performs the surgery or gives the maternity care, no payment will be made for anesthesia. We will not pay for charges related to local anesthesia. We will provide coverage for anesthesia related to dental care of 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.

Q. **Mammography Screenings.** We will provide coverage for the Hospital and medical costs related to mammography screenings for occult breast cancer as indicated below:

(i) **Women At Risk.** We will provide coverage for a mammogram for women of any age who have a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer if the mammogram is recommended by a Physician.
(ii) **Women 35 Through 39 Years Of Age.** We will provide coverage for one baseline mammogram for women 35 through 39 years of age.
(iii) **Women 40 Years Of Age And Older.** We will pay for one mammogram in each calendar 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 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.

We will not provide coverage for mammography screenings under this Section if benefits for mammography screenings have been covered under Section Six during the same calendar year.

R. **Ultrasound.** We will provide coverage for ultrasound services related to an injury or illness only when, in our sole judgment, the service was Medically Necessary to diagnose your injury or illness. We will provide coverage for one ultrasound service related to pregnancy when performed after the 12th week of pregnancy to identify abnormalities or determine gestational age, unless In-Network benefits have already been provided for one ultrasound. We will consider additional ultrasound services related to pregnancy only when, in our sole judgment, the service was Medically Necessary. Routine screening for determination of pregnancy will not be considered Medically Necessary.

S. **Outpatient Laboratory Tests.** We will provide coverage for diagnostic laboratory tests when rendered in an outpatient department of a Hospital or in a Physician's office. We will also pay for laboratory tests performed by an independent licensed laboratory when ordered by your Physician. The tests must be directly related to your illness or injury. We will not, however, pay for any diagnostic laboratory test when performed in conjunction with routine or periodic physical examinations, premarital or similar examinations.

T. **Cervical Cytology Screening (Pap Smears).** We will provide coverage for one cervical cytology screening for cervical cancer and its precursor states each calendar year for women 18 years of age or older. The screening may be provided in the outpatient department of a Hospital or in a provider's office. Cervical cytology screening shall include an annual pelvic examination, collection and preparation of Pap Smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap Smear. However, no benefit will be available under this Section if a benefit for a cervical cytology screening has already been provided under Section Six of this Plan during the same calendar year.

U. **Well Child Care.** We will provide coverage for the well child care benefits described below for covered children from the date of birth through the attainment of 19 years of age.

- an initial newborn check-up in the Hospital and well child visits including a medical history, a complete physical examination, developmental assessment, anticipatory guidance and laboratory tests ordered at the time of the visit which are performed in the office or in a clinical laboratory. All well child visits must be provided in accordance with the standards and frequency schedule of the American Academy of Pediatrics.
- necessary immunizations against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza type B and hepatitis B, prevnar, varicella, as well as any other immunizations specified by the American Academy of Pediatrics.

Coverage for these services shall be provided only to the extent that such services are provided by or under the supervision of a Physician or Other Medical Professional licensed under Article 139 of the Education Law whose scope of practice pursuant to such law includes the authority to provide these services. The well child visits can be performed by the Physician or Other Medical Professional in their office or in a Hospital. We will not provide coverage for well child visits if services have already been covered under Section Six during the same calendar year.

V. **Second Medical Opinions.** 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 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.

We will not provide coverage for a second medical opinion under this Section if benefits for a second medical opinion for the same condition have been covered under Section Six.

W. **Chiropractic Care.** We will provide coverage for Chiropractic Care when rendered during an office visit and provided within the scope of the Physician's or chiropractor's license. Chiropractic Care means Medically Necessary services rendered in connection with detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.

Chiropractic visits will be reviewed to determine whether they were Medically Necessary. We will not pay for any visits which we determine, in our sole judgment, were not Medically Necessary.

X. **Diagnostic Screening For Prostatic Cancer.** We will provide coverage for the Hospital or medical costs related to diagnostic screening for prostatic 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:

- 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; and
- 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. We will not provide coverage for the annual exam under this Section if coverage for these services has already been provided under Section Six during the same calendar year.

Y. **Radiation Therapy And Chemotherapy.** We will provide coverage for radiation therapy and services and medications related to non-experimental cancer chemotherapy and cancer hormone therapy in an outpatient department of a Hospital or Physician'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.

Z. **Surgery For Breast Reconstruction.** We will provide coverage for all stages of reconstructive surgery of the breast on which the mastectomy has been performed. We will also cover reconstructive surgical procedures on the other breast to produce a symmetrical appearance. Coverage will be provided for all such services rendered in the manner determined appropriate by you and your attending Physician.

AA. **Diagnosis and Treatment.** Except as otherwise limited by any other provision of this Contract, we will provide coverage for the services of a Physician or by another Provider for the diagnosis and treatment of your disease, injury, or other condition. This includes surgical procedures, visits and consultants.

You must pay a $25 copayment for services provided at an urgent care facility.

BB. **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:

(i) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
(ii) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
(iii) on a prescribed drug regimen posing a significant risk of osteo-porosis; or
(iv) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
(v) 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.

CC. **Alive & Lively 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. Certain programs are subject to a copayment. Consult your Provider Directory for information as to programs subject to a copayment and the amount of the applicable copayment.

11. **Infertility.** 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 and ultrasound.

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

12. **Out-Of-Network Deductible.** Except as otherwise indicated, you must first pay the first $750 in each calendar year for the services provided under this Section, except that if other than individual coverage applies, after members of the same family covered under this Plan have paid, in the aggregate, $1,500 for the services provided under this Section in the same calendar year, no other member of the same family covered under this Plan will be subject to the deductible for that calendar year for services provided under this Section. Visit fees or copayments for In-Network Benefits covered under the other Sections of this Plan do not count towards the satisfaction of the deductible.

13. **Our Payments.** After application of the deductible, we will pay the following:

    A. **Inpatient Hospital Care.** We will pay 70% of the amount the Hospital has agreed to accept from us as payment in full, 70% of the amount specified under state law or 70% of charges, whichever is applicable, for covered services under this Section.

    B. **All Other Services Covered Under This Section.** Except as specifically provided otherwise, we will pay the lesser of 70% of the actual charge or 70% of the amount listed in our Schedule of Allowances for this Plan for all of the other services covered under this Section. The Schedule of Allowances we use with this Plan lists dollar amounts for the various medical procedures which we cover. The amounts in the Schedule may be changed by us from time to time. A copy of the Schedule of Allowances we use with this Plan is on file in the Office of the Superintendent of Insurance of the State of New York in Albany, New York. The Schedule may also be inspected at our office.

    C. **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 Medical Professional if the Physician or Other Medical Professional is employed by the Hospital and charges for the services are billed by and retained by the Hospital.

14. **Copayments.** In addition to the payment of the deductible, you must pay the following copayments:

    A. For the inpatient Hospital services described above, you must pay the remaining 30% as your copayment.

B. For the mental health visits described in this Section, you must pay 50% of the charges or 50% of the amount set forth in our Schedule of Allowances as your copayment, whichever is applicable, for the items or services received. In addition, where the charges exceed the amount of our payment, you must pay 100% of that excess amount.

C. Except when otherwise indicated for all of the other services covered in this Section, you must pay 30% of the charges or 30% of the amount set forth in our Schedule of Allowances, whichever is applicable, for the services received as your copayment. In addition, where the charges exceed the amount of our payment, you must pay 100% of that excess amount.

15. **Your Additional Payment Responsibility.** Our payment for Out-Of-Network benefits covered under this Section is based upon the amount we would have paid a Participating Provider for the services rendered. When the covered service has been received from a Non-Participating Provider who does not have an agreement regarding payment for Out-Of-Network services covered under this Section, you must also pay the amount, if any, that the provider's actual charge exceeds our payment.

16. **Maximum Payment By You.** After you have spent $2,500, or after all members of your family covered under this Plan, have spent, in the aggregate, $5,000 in a calendar year for the deductible and copayments under this Section neither you nor any members of your family will have to pay any further copayments for any services provided under this Section for the remainder of the calendar year. Our payment for covered services will, for the balance of the calendar year, increase from 70% to 100% of the amount in which our payment is based. However, any amounts you are obligated to pay in excess of the amount listed in our Schedule of Allowances or in excess of any dollar limitation on benefits will not be counted in determining when you, or a member of your family, have reached the maximum payments in a calendar year. In addition, you will remain responsible for all charges in excess of the amount listed in our Schedule of Allowances even after the thresholds are met.

Section Twelve - Exclusions

In addition to certain exclusions and limitations already described in this Plan, we will not make payment 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 provided during that stay after the effective date of coverage and only to the extent those services are not covered under any other HMO or health insurance policy.

2. **Government Hospital.** Except as otherwise required by State or Federal law, we will not pay for care 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 Preferred or Participating Hospital. However, we will pay for care covered under this Plan in such a Hospital if, because of an Emergency Condition you are taken to one of these Hospitals for Emergency Care 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 was Medically Necessary and that your medical condition prevents your transfer to another Hospital.

3. **No-Fault Automobile Insurance.** We will not pay for any service or care if benefits are recoverable or have been recovered by mandatory no-fault automobile insurance until you have used up all the benefits under the mandatory no-fault policy. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under 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 Contract.

4. **Workers' Compensation.** We will not pay for any care for any injury, condition or disease if payment is or may be available to you under a Workers' Compensation Law or similar legislation. We will not make any payments if you do not claim the benefits you are, or would have been, entitled to receive under the Workers' Compensation Law. We will not make payments if you do not receive benefits because a proper or timely claim for the benefits available to you under the Workers' Compensation Law was not submitted or you fail to appear at a Workers' Compensation Hearing. Also, we will not make any payments even if you bring a lawsuit against the person who caused your injury or condition and even if you receive money from that lawsuit and you have repaid the Hospital and other medical expenses you received payment for under the 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 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 65This 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 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 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 that Medicare is the secondary payor as set forth in the Medicare Law.

7. **Non-Acute Hospital Or Medically Unnecessary Care.** We will not pay for a Hospital stay or 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 a Utilization Review and an External Appeal.

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. **Custodial Care.** We will not pay for custodial care. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes activities of daily living such as help in transferring, bathing, dressing, eating, toileting and other such related activities.

10. **Unauthorized Services.** Except for emergency care and benefits provided under Section Eleven, we will not provide benefits for any service or care unless treatment is performed, prescribed, arranged or authorized by a Preferred Physician or other Preferred Provider. For some services, the approval of the Medical Director is also required.

11. **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, in our sole judgment, such services are experimental, investigational, or obsolete. Experimental or investigational means that 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, investigational, or obsolete services if approved by an External Appeal Agent as described in Section Sixteen.

12. **Cosmetic Surgery.** We will not pay for any services in connection with elective cosmetic surgery which is primarily intended to improve your appearance as determined in our sole discretion, unless a Medical Necessity determination is rendered after the completion of the Utilization Review Process as described in Section Fifteen. 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.

13. **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, 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 medical 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 if the care is rendered within 12 months of the accident, and for dental care and treatment necessary due to congenital disease or anomaly as long as the services are otherwise covered under this Plan.

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

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

16. **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.

17. **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 in our sole discretion, they are Medically Necessary. 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. Morbid obesity is defined as weighing more than twice your recommended body weight for your height and sex.

18. **Court Ordered Services.** We will not pay for any court ordered services unless they are Medically Necessary and except as pursuant to Section Eleven, the care is provided by a Preferred Physician or Provider.

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

20. **Sex Change.** We will not pay for services or supplies for or related to sex transformations, unless, in our sole discretion, it is determined the transformation is Medically Necessary.

21. **Infertility.** We will not pay for services or supplies for or related to in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and cloning.

22. **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.

23. **Charges For Standby Service.** We will not pay for charges related to a Physician or Other Medical Professional on standby in case their services are needed. We will only pay for charges related to covered services actually performed.

24. **Voluntary Sterilizations.** We will not pay for any services, supplies or care for or related to the reversal of a voluntary sterilization.

25. **Services Furnished Pursuant To A Referral Prohibited By State Law.** 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.

26. **Methadone Maintenance.** We will not pay for services or supplies in connection with the methadone maintenance programs unless, in our sole discretion, we determine they are Medically Necessary.

27. **Plan Limitations.** We will not pay for any other limitation or exclusion stated in this Plan.

28. **Routine Care.** Except as otherwise provided in this Plan, we will not pay for any services in connection with the routine or periodic physical or screening examinations. We will provide coverage for well child care, mammography screenings, cervical cytology screenings, and prostate cancer screening.

29. **Eyeglasses Or Hearing Aids.** Except as otherwise provided, we will not pay for examinations related to prescriptions for eyeglasses, contact lenses, or hearing aids, or for the fitting of those items.

30. **Drugs, Medicines, And Medical Supplies.** Except as otherwise provided in this Plan, we will not pay for drugs, medicines, and disposable medical supplies.

31. **Inpatient Services For Chemical Abuse.** We will not pay for inpatient services for the diagnosis, treatment, or rehabilitation of chemical abuse or chemical dependence.

Section Thirteen - Coordination of Benefits

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

   - any group or blanket insurance policy, including HMO and other prepaid group coverage; except that blanket school accident coverages or such policies offered to substantially similar groups (e.g., Boy Scouts, Youth Groups) shall not be considered a health insurance policy;
   - any group or blanket insurance policy, including HMO and other prepaid group coverage; except that blanket school accident coverages or such policies offered to substantially similar groups (e.g., Boy Scouts, Youth Groups) shall not be considered a health insurance policy;
   - any self-insured or non-insured plan, or any other plan arranged through any employer; trustee; union; employer organization or employee benefit organization;
   - any BlueCross, BlueShield or other service type group plan or group remittance subscriber contract;
   - any coverage under governmental programs, or any coverage required or provided by statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; or
   - medical benefits coverage in group and individual mandatory automobile traditional fault type contracts.

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

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

   B. If you are covered under one policy as an employee and you are only covered as a dependent under the other policy, the policy which covers you as an employee will be primary.

   C. Subject to the provisions in Paragraphs (i) and (ii) below, if you are covered as a child under both policies, the policy of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the policy which covered the parent longer is primary.

      (i) If the other policy does not have the rule described above, but instead has a rule based on gender of a parent and, as a result, the policies do not agree on which shall be primary, the policy under which you are the dependent of a male will be primary.
      (ii) There are special rules for a child of separated or divorced parents. If your parents are separated or divorced, benefits are determined in this order:

         - first, the policy of the parent with custody of the child;
         - then, the policy of the spouse of the parent with custody of the child;
         - finally, the policy of the parent not having custody of the child.

      However, if the terms of a court decree state the order of responsibility and the entity obligated to pay or provide the benefits of the policy of that parent has actual knowledge of the court decree, that policy shall be primary.

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

E. If none of the above applies, then the policy which has covered you for the longest time will be primary.

The above rules apply whether or not you actually make claim under both policies.

3. **Payment Of The Benefits When This Plan Is Secondary.** When this Plan is secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other policy and under this Plan do not exceed the amount we would have paid if we were primary.

4. **Right To Receive And Release Necessary Information.** We have the right to release or obtain information which we believe necessary to carry out the purpose of this section. We will not notify you or obtain your consent before releasing or obtaining information except as required by applicable Federal and State laws and regulations. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information which we request. If you do not furnish the information to us, we have the right to deny payments.

5. **Payments To Others.** We may make payment, in our sole discretion, to any other person, insurance company or organization the amount which it paid for your covered services and which we decide we should have paid. These payments are the same as benefits paid 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 Fourteen - Termination of Your Coverage and Your Right to a New Contract after Termination

Described below are reasons why this Plan may terminate, or your coverage under this Plan may terminate.

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 name and/or 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.

   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; or
   - 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.

B. **Termination By Us.** We may terminate this Plan for any of the following reasons:

- 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;
- if we discontinue the entire class of contracts to which your Group Plan belongs. We will send you at least 90 days written notice that this Plan will be terminated in this manner. This termination will be done uniformly, without regard to any health status-related factor;
- you no longer live, work, or reside in Our Operating Area or the area we are authorized to do business. Termination for this reason will be done uniformly without regard to any health status-related factors;
- 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.; or
- for any reason authorized under New York State Insurance Law Section 4305.

2. **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.

3. **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. Your spouse or children may be entitled to purchase a new contract as direct payment subscribers.

4. **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 purchase a new contract as a direct payment subscriber.

5. **Termination Of Coverage Of A Child.** The coverage of your child under this Plan will automatically terminate on the date the child marries, or on the date the child becomes 19 years of age, or, if the child is over 19 years of age and covered under this Plan as a disabled child, on the date the child is no longer incapable of self-sustaining employment; or on the date a student reaches age 25, marries, or is no longer a full-time student, whichever comes first. The child may be entitled to purchase a new contract as a direct payment subscriber.

6. **Benefits After Termination.**

A. 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, as determined in our sole discretion. The extension of benefits shall only apply to services for the sickness, injury, or pregnancy which caused your total disability.

B. The extension of benefits period under this Plan shall continue during an uninterrupted period of total disability until the first of the following dates:

- a date you are, in our sole judgement, no longer totally disabled; or,
- a date twelve months from the date your coverage under this Plan terminated.

We will not provide coverage for more care than you would have been entitled to receive if your coverage under this Plan had not terminated. We will not provide coverage if coverage is afforded for the total disability under another group plan.

7. **Temporary Continuation Of Coverage.** Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Also, if you are not entitled to temporary continuation of coverage under COBRA, you may be entitled to temporary coverage under the New York State Insurance Law. 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.

8. **Supplementary Conversion And Continuation Rights.** Under State law, a member of a reserve component of the armed forces of the United States, including the National Guard, who enters active duty has, if certain conditions are met, the right to a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty. If you enter active duty, call or write your employer or us to find out about your rights under State law.

9. **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 within 45 days after termination of this Plan or within 45 days after termination of your coverage under this Plan. You must also pay the first premium for the new contract within this same 45-day period. You can purchase the new contract without evidence of insurability.

   However, notwithstanding the above, if we determine, in our sole judgment, 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.

10. **The New Contract.** The new contract will be a comprehensive or comparable type contract. We may elect to issue our standardized direct pay product we offer to direct pay subscribers.

Section Fifteen - Utilization Review Procedures and Appeals

Utilization Review Procedures. Utilization review is a procedure used to determine if services are or were Medically Necessary. Utilization review will occur whenever judgments are rendered which pertain to medical necessity and the provision of services or treatments. If you have a service or benefit denied because of lack of medical necessity, the utilization review process allows you to have this denial reviewed. All denials will be made by qualified clinical personnel and notices of denials will include information about the basis of our decision and further appeal rights, if any.

A. **Initial Determination.**

(i) You may either make your request for review in writing or orally, 24 hours a day, 7 days a week. The request should include the name and identification number of the covered member of the family for whom the review is requested and the facts relating to the case. Your request should be sent to:

BlueShield of Northeastern New York
Customer Service Department
1-518-220-4600
or call: 1-800-888-1238

Our 800 number is staffed 40 hours a week during normal business hours. During all other times you may leave a message on our confidential voice mail. We will contact you by telephone within one (1) business day after receipt of your message.

(ii) Once all necessary information is received, a determination will be made according to the following time frames:

- Decisions regarding services which require pre-authorization will be made, and notice of the decision will be provided to you or your provider by phone and/or in writing within three (3) business days.
- Decisions regarding continued or extended services, or additional services for a continued course of treatment, shall be made and notice provided to you or your provider by phone and/or in writing within one (1) business day. This notice shall include the number of extended services, the new total of approved services, the date the services are authorized to begin and the date the next utilization review is scheduled to take place.
- All retrospective reviews regarding services that have already been delivered or received will be made within thirty (30) calendar days.

B. **Right To Reconsideration.** If we did not discuss the matter with your provider and we make an adverse determination, your provider has the right to reconsideration. This decision will be made within one (1) business day of receipt of the request, except in the case of retrospective reviews.

C. **Appeal Of An Adverse Determination/Utilization Management Appeals Process.** If you do not agree with our utilization review decision, you have the right to appeal. There are two types of Utilization Management Appeals: expedited and standard appeals. In both cases, the appeal will be reviewed by someone other than the person who made the initial determination.

(i) **Expedited Appeal.** An expedited appeal is used for adverse determinations involving continued or extended health care services, procedures or treatments, or additional services for an insured undergoing a continued course of treatment prescribed by a health care provider. It also includes adverse determinations in which your provider believes an immediate appeal is warranted, except any retrospective determinations. You will have the opportunity to discuss your appeal with both the nurse and physician who reviewed your case within one (1) business day of receipt of your appeal. A determination will be made on your appeal within two (2) business days of receipt of all necessary information. We will notify you immediately of our decision by telephone. We will send you written notice within twenty-four hours of our decision. If you do not receive a satisfactory answer through the expedited appeal process, you may use the standard appeal process described below or the external appeal process.

(ii) **Standard Appeal.** For all other Utilization Management Appeals you have forty-five (45) days from receipt of the utilization review determination to request an appeal in writing or by telephone. You, your designee or your health care provider will receive written

acknowledgment of our receipt of your appeal within fifteen (15) days. Upon receipt of all necessary information, your appeal will be reviewed and a determination will be made within sixty (60) calendar days. You, your designee and, where appropriate, your health care provider will be notified in writing within two (2) business days of this determination. The notice of appeal determination will include the following:

- the reasons for the determination and where the adverse determination is upheld on appeal, the clinical rationale for the determination; and
- a notice of your right to an external appeal, as described below.

If you have requested an internal appeal of a utilization review determination and we have failed to make a decision on your appeal within the specified time frame, we are required to cover the service, subject to all other conditions of your coverage.

Follow the Utilization Management Appeals Process as described above to appeal a denial for medical necessity, experimental or investigational only.

Section Sixteen - External Review

1. **Your Right To An External Appeal.** Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if we have 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 of New York to conduct such appeals.

2. **Your Right To Appeal A Determination That A Service Is Not Medically Necessary.** If we have denied coverage on the basis that the service is not Medically Necessary, you may appeal to an External Appeal Agent if you satisfy the following two (2) criteria:

   - the service, procedure or treatment must otherwise be a covered service under your Plan; and
   - you must have received a final adverse determination through the first level of our internal appeal process and we must have upheld the denial or we must agree in writing to waive any internal appeal.

3. **Your Rights To Appeal A Determination That A Service Is Experimental Or Investigational**.

   If you have been denied coverage on the basis that the service is experimental or investigational treatment, you must satisfy the following two (2) criteria:

   - the service must otherwise be a covered service under your Plan; and
   - you must have received a final adverse determination through the first level of our internal appeal process and we must have upheld the denial or we 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 us or one for which there exists a clinical trial (as defined by law).

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

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

For the 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.

4. **The External Appeal Process.** If, through the first level of our 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 we 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. We will provide an external appeal application with the final adverse determination issued through the first level of our internal appeal process or our written waiver of an internal appeal.

   You may also request an external appeal application from New York State at 1-800-400-8882. Submit the completed application to the State Department of Insurance at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward your 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 we based our denial, the External Appeal Agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an Expedited Appeal (described below), we do not have a right to reconsider our decision, the External Appeal Agent must try to notify you and us by telephone or facsimile of that decision.

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

   If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, 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 us by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, we will provide coverage subject to the other terms and conditions of this Plan. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and us. The External Appeal Agent's decision is admissible in any court proceeding.

5. **Requesting an external appeal.** You or your attending physician may obtain an external appeal application from the State Insurance Department or by contacting us. We will send an external appeal application to you when we have made a final adverse determination that is subject to external appeal. The application will provide clear instructions for completion.

   To request an external appeal application from the New York State Insurance Department please contact them at this addresses:

   New York State Insurance Department
   One Commerce Plaza
   Albany, NY 12257
   1-(800) 400-8882
   or at their website: www.ins.state.ny.us

   You must file your application for an external appeal with the State Insurance Department within forty-five (45) calendar days after receiving a final adverse determination of our first level appeal process or within forty-five (45) calendar days after receiving a letter from us waiving the internal utilization review appeal process. We do not have the authority to grant extensions of this deadline.

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

   You will lose your right to an external appeal if you do not file an application for an external appeal within forty-five (45) calendar days from your receipt of the final adverse determination from the first level internal plan appeal. You (and your doctors) must sign an appropriate authorization to release all pertinent medical information concerning your medical condition and request for services.

   If you have any questions, please contact our Customer Service Department at:

   30 Century Hill Drive
   Latham, New York 12110
   Phone: 1-518-220-4600
   Toll Free: 1-800-888-1238

   Our telephone service hours are:
   8:00 am. to 7:00 pm.

6. **Exclusions.** In general, we do not cover experimental or investigation treatments. However, we will cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with this Paragraph. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

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 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 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, Physicians, health care providers, clinics, other providers of health care, other insurers, payors 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 Plan operations as set forth in 11NYCRR§420.17(b). By accepting this Plan you agree to assist us in obtaining your medical records or other information we deem necessary.

4. **Plan Amendments.** We may amend this Plan at the time of coverage renewal, or as otherwise permitted by law or regulation, or as permitted by the Superintendent of Insurance. If we amend this Plan as indicated above, we will provide notice as required 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.

5. **Who Receives Payment Under This Plan.** Payments for services provided by a Preferred or Participating Provider will be made by us directly to the Preferred or Participating Provider. If you receive these services from a Non-Preferred or Non-Participating provider, we reserve the right to pay either you or the Non-Preferred or Non-Participating provider. If you receive services that are not covered by this Plan, you are responsible for the charges.

6. **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.

7. **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, your premiums must be paid in full

8. **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 to us within 60 days of the date of our notification the amount of the overpayment.

9. **Notice Of Claim.** In order for us to process claims for payment under this Plan for services provided by a Non-Preferred or Non-Participating Provider, you, or on your behalf, the Non-Preferred or 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 one year from the date of service. No payment will be made for any service for which we do not receive timely claim submission as described above. Claim submissions by Preferred or Participating Providers shall be governed by our Agreement with the Preferred or Participating Provider.

10. **Right To Develop Guidelines And Administrative Rules.** We may develop or adopt standards which describe in more detail when we will make or will not make payments under this Plan and administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Plan, including without limitation thereto the power to conduct utilization review and quality review, the power to construe this Plan, to determine all questions arising under this Plan and to make and establish (and thereafter change) rules and regulations and procedures with respect to this Plan. If you have a question about the standards which apply to a particular benefit or the administrative rules, you may contact us and we will explain the standards or rules.

11. **Our Right To 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 will be subrogated and succeed to the right of recovery against the party responsible for your illness or injury to the extent of the benefits we have paid. This means that 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.

    We are also entitled to be reimbursed for the benefits we have paid from a settlement or a judgment you receive from the party responsible for your illness or injury, if the settlement or judgment you receive from that party specifically identifies or allocates monetary sums directly attributable to expenses for which we have paid benefits.

    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. 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

12. **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.

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


OPEIU 212
UNION LABEL

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

Inter-Plan Arrangements Disclosure

1. **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. **BlueCard® 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.

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:

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

(ii) 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

(iii) 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.

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.

B. Non-Participating Healthcare Providers Outside Our Service Area

1. Member Liability Calculation

When covered healthcare services are provided outside of our service area by non-participating healthcare providers, the amount(s) a member pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

2. Exceptions

In some exception cases, we may pay claims from non-participating healthcare providers outside of our service area based on the provider's billed charge, such as in situations where a member did not have reasonable access to a participating provider as determined by us or by applicable state law. In other exception cases, we may pay such a claim based on the payment we would make if we were paying a non-participating provider inside of our service area, as described elsewhere in this contract, where the Host Blue's corresponding payment would be more than our in-service area non-participating provider payment, we may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

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

Initial Claim Determinations, Grievance, Appeal, and External Appeal Amendment to your Traditional Blue Contract, Rider or Group Plan Issued By BlueShield of Northeastern New York

This Amendment updates your BlueShield of Northeastern New York Contract, Group Plan, and Riders regarding procedures for initial claim determinations and your right to file a Grievance, Appeal, or External Appeal. If this amendment conflicts with a provision in your Contract, Group Plan, or Rider, the provisions in this amendment control. This amendment takes effect on January 1, 2003 and will apply to all initial claim determinations, grievances, and appeals on or after that date, subject to the provisions described below.

1. **Initial Claim Determinations**

A. **Pre-Service Claims.** A pre-service claim involves procedures or treatments that require prior authorization according to your Contract, Group Plan, or Rider.

(i) **Non-Urgent (Complete Claim).** If all necessary information has been provided, we will make a decision regarding your pre-service claim and provide notice by telephone and in writing to you or your authorized representative and your healthcare provider within three (3) business days after receipt of your claim.

(ii) **Non-Urgent (Incomplete Claim).** If all necessary information has not been provided, we may provide you with an opportunity to submit the missing information. If we allow the extension of time to submit the missing information, we will notify you in writing within fifteen (15) calendar days after receipt of your claim of the specific missing information. We will allow you or your authorized representative up to forty-five (45) calendar days from the date of our notice to provide the missing information.

If we receive all the necessary information within the forty-five (45) day period, we will make a decision and provide notice by telephone and in writing within three (3) business days of receipt of the information. If only partial information is received, we will make a decision and provide written notice within fifteen (15) calendar days from receipt of the partial information. If we do not receive any information by the end of the 45-day period, we will make a decision and provide written notice within fifteen (15) calendar days from the end of the 45-day period.

We are not required to grant you an extension of time to submit the missing information and may, in the alternative, deny the claim. If the claim is denied, you may request a grievance or medical management appeal, whichever applies.

(iii) **Urgent (Complete Claim).** If all necessary information has been provided, we will render a decision and provide notice by telephone and in writing within seventy-two (72) hours of receipt of your claim.

(iv) **Urgent (Incomplete Claim).** If all necessary information has not been submitted, we will provide you with an opportunity to submit the missing information. We will notify you or your authorized representative within twenty-four (24) hours after receipt of your claim of the specific information needed to complete the claim. You or your authorized representative will be allowed forty-eight (48) hours from the date of our notice to provide us with the missing information. We will render a decision and provide notice within forty-eight (48) hours after receiving the information. If the missing information is not provided, we will render a decision and provide notice within forty-eight (48) hours after the end of the period of time afforded you to provide the missing information.

(v) **Improperly Filed Pre-Service Claim.** If you or your authorized representative fail to follow our procedures for properly filing a pre-service claim, we will notify you or your authorized representative verbally or in writing within five (5) calendar days after receipt of your claim of the proper procedures for filing a claim. If the pre-service claim involves urgent care, we will notify you within twenty-four (24) hours after receipt of your claim. We will only provide notice within these timeframes if the following requirements are satisfied:

- the initial communication by you or your authorized representative is received by our Medical Management Area
- the communication includes the name of the claimant
- the specific medical condition or symptom is indicated; and
- a specific treatment, service or product is requested.

If you or your authorized representative fail to submit a pre-service claim that meets the above requirements, it will not be considered a claim and will be returned to you or your representative with instructions on properly filing the claim.

B. **Post-Service Claims**

(i) **Complete Claim**. If all necessary information has been submitted, we will make a decision and provide written notification to you or your authorized representative within thirty (30) calendar days of receipt of your claim.

(ii) **Incomplete Claim.** If we have not received all the necessary information, we may provide you or you authorized representative an opportunity to submit the missing information. If we allow the extension of time to submit the missing information, we will notify you in writing within thirty (30) calendar days after receipt of your claim of the specific missing information.

You or your authorized representative will have forty-five (45) calendar days from the date of our notice to submit the missing information. If we receive any of the information requested, we will render a decision and provide notice in writing within fifteen (15) calendar days after receipt of the information.

If none of the information is received, we will render a decision within fifteen (15) calendar days after the end of the forty-five (45) calendar day period provided to you to submit the missing information.

C. **Concurrent Care Claims**. Concurrent care claims involve continued or extended healthcare services or additional services for a member undergoing a course of continued treatment prescribed by a healthcare provider.

(i) **Non-Urgent (Complete Claim).** If all necessary information has been provided, we will make a decision and provide notice by telephone and in writing to you or your authorized representative within one (1) business day after receipt of your request for an extension of care.

(ii) **Non-Urgent (Incomplete Claim).** If we have not received all the necessary information, we will make a decision and provide notice to you or your authorized representative within fifteen (15) calendar days after receipt of your request for an extension of care.

(iii) **Urgent Claim.** If you or your authorized representative requests an extension of a course of treatment beyond the period of time or number of treatments already approved by us which involves urgent care, we will make a decision and provide notice to you or your representative within twenty-four (24) hours after receipt of the request. We are only required to render a decision within twenty-four (24 hours) if you or your authorized representative made the request for the extension of care at least twenty-four (24) hours prior to the scheduled expiration of the services.

If the request is not made at least twenty-four (24) hours prior to the scheduled expiration of services, we will make a decision and provide notice within one (1) business day of your request if we have received all the necessary information. If we have not received all the necessary information, and the request was not made at least twenty-four (24) hours prior to the expiration of the services, we will make a decision within seventy-two (72) hours of your request.

(iv) **Plan Reduction or Termination of Concurrent Care.** If we are reducing or terminating an already approved course of treatment, other than due to a Plan amendment or termination of your contract or group plan, we will provide you notice and the right to an appeal prior to our reduction or termination of the treatment. You or your authorized representative will have twenty-four (24) hours to submit the appeal of the proposed reduction or termination of the treatment. A decision on the appeal will be made and notice provided to you or your representative by telephone and in writing within seventy-two (72) hours or two (2) business days after receipt of the appeal, whichever occurs first.

(v) **Notification.** Notice of a decision on a concurrent care claim will be provided to you or your authorized representative by telephone and in writing within the time frames mentioned above.

Notification of an approval of continued or extended concurrent care services will include the following information, if applicable:

- the number of extended services approved
- the new total of approved services
- the date the services are authorized to begin; and
- the date the next utilization review is scheduled to take place.

D. **Right to Reconsideration.** In situations where there has been a denial of services as not medically necessary without attempting to discuss the matter with your provider who

recommended the service, procedure or treatment under review, your provider may have the opportunity to request a reconsideration of the denial. The reconsideration review will occur within one (1) business day of receipt of the request, except in cases where the reconsideration request is for services which have already been provided.

E. **Utilization Review.** Utilization review is a process used to determine if services are or were medically necessary or experimental or investigational in nature. Utilization review will occur whenever judgments are rendered pertaining to medical necessity and the provision of services or treatments. In the case of a denial for medical necessity, qualified clinical personnel will make all decisions. Notices of denials will include information about the basis of our decision and further appeal rights, if any.

   You may make your initial request for a utilization review determination in writing or verbally, 24 hours a day, 7 days a week. The request should include the name and ID number of the member for whom the review is requested and the facts relating to the case.

   The appeal process for chiropractic services, mental health, and chemical dependency services is handled by the organization managing the benefits for these services. You can access the utilization review and appeal process for chiropractic services by calling toll-free (888) 774-7601. Additionally, you can access the appeal process for mental health and chemical dependency services by calling toll-free 1-800-888-1238.

   You may request a utilization review for all other services by contacting:

   Customer Service Department
   BlueShield of Northeastern New York
   PO Box 15013
   Albany, New York 12212
   1-518-220-4600 or toll free at 1-800-888-1238
   Services hours: 8:00 a.m. to 7:00 p.m. Monday - Friday

   Our telephones are staffed at least forty (40) hours a week during normal business hours. During all other times, you may leave a message on our confidential voice mail. We will contact you by telephone within one (1) business day after receipt of your message.

2. **Initiating a Grievance.** Our grievance procedure is designed to ensure a timely review of any decision regarding a service which is believed to be covered under your Contract, Group Plan, or Rider. A grievance is a request to change a contractual determination made by us other than a determination that a service is not medically necessary or is experimental or investigational. A request to change a determination regarding the medical necessity of the service or the experimental/investigational nature of the service is handled under the Medical Management Appeals Procedure explained below.

   Examples of issues which may be reviewed under the grievance procedures include, but are not limited to, the following:

   - any denial, reduction, termination of or failure to make payment in whole or in part, for a benefit other than for medical necessity or experimental/investigational

   - any denial, reduction, termination of or failure to provide or make payment based on a determination that a person is not eligible for coverage under the Plan.

   Any time we determine that a benefit is not covered under your Contract, Group Plan, or Rider, you will receive notification of our grievance procedures. You may file a written or oral grievance up to 180 calendar days after you receive our original determination. Your request

for a grievance should state the name and identification number of the member for whom the benefit was denied. It should also describe the facts and circumstances relating to the case. You may submit any oral or written comments, documents, records, or other information relevant to the grievance. You may initiate a grievance by calling our Customer Service Department. The telephone number for our Customer Service Department is located on the back of your Identification Card. We will also provide the Customer Service numbers and service hours on the grievance notice you will receive with any denial. We can communicate with non-English speaking members through the AT&T translator service. You may also file a written grievance with our Customer Service Department at the address included on our grievance notice.

A Customer Service Representative that was not involved in the initial determination and who is not a subordinate of the initial reviewer will thoroughly research the case by contacting all appropriate departments and providers and reviewing all relevant documents, records, and other information submitted.

If the issues are of a clinical nature, it will be reviewed by a healthcare provider who was not involved in our initial determination and who has appropriate training and experience in the field of medicine involved in medical judgment.

You will be contacted within the following time frames:

Urgent Care Claims:	when a delay would significantly increase the risk to your health, a decision will be made and communicated to you or your authorized representative in writing within seventy-two (72) hours after receipt of the grievance.
Pre-Service Claims:	In writing within thirty (30) calendar days after receipt of grievance.
Post-Service Claims:	In writing within sixty (60) calendar days after receipt of grievance.

Our grievance decision will include:

- the detailed reasons for our determination
- references to the provisions of your Contract, Group Plan, or Rider upon which the decision was based
- if applicable, a statement that we relied upon a rule, guideline or protocol and a copy will be provided free of charge upon request
- a description of any additional information necessary for you to perfect your claim, and why the information is necessary; and
- the clinical rationale in cases requiring a clinical determination.

A. **Unresolved Disputes.** We recommend that you follow the grievance process to remedy any issues concerning your coverage. If you are not satisfied with our decision, you may contact the New York State Insurance Department at the address below:

New York State Insurance Department
One Commerce Plaza
Albany, NY 12257

We will not retaliate or take other discretionary action against a member because they have filed a grievance.

3. **Medical Management (MM) Appeals Procedure.** At times you may receive a letter explaining that we have reached an adverse determination. This means that we have decided that an admission, extension of a stay, or other health care service is not medically necessary.

   You have the right to appeal this decision or appoint a representative to conduct the appeal on your behalf (see below "Designating a Representative"). Hospitals, other healthcare providers, or someone you choose to represent you may assist in your appeal.

   Your notice of an adverse determination will include instructions on how to initiate standard and expedited internal and external appeals and instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used. If we fail to render an internal appeal determination within the specified time frame, the initial adverse determination will be reversed.

   A. **Expedited Appeals.** Expedited or immediate appeals are available to you if you want to appeal an adverse decision that involves:

      - continued or extended healthcare services
      - procedures, treatments or additional services for a member who is undergoing a course of continued treatment prescribed by his or her health care provider
      - a situation where your healthcare provider believes an immediate appeal is needed. This does not apply in situations where the services have already been provided.
      - any situation in which a delay in the appeals process would increase risk to your health.

      We encourage our physicians and specialty providers to share information by telephone and/or fax. You, or the person acting for you, can contact both the nurse and physician who reviewed your case to talk about the appeal. You can do this within one (1) business day of the date we receive the notice of expedited appeal. All necessary information, including the appeal determination, shall be transmitted to you or your authorized representative by telephone, fax, or other expeditious manner. You may communicate with us via telephone or fax.

      We will make a decision about the expedited appeal within two (2) business days after receipt of all necessary information or within seventy-two (72) hours, whichever is less. We will notify you immediately of our decision by telephone. Written notice will be sent no later than twenty-four (24) hours after the decision.

      If we do not have all the necessary information, we will notify you and your provider by telephone or fax to request the necessary information, followed by written notification.

      When you receive our final adverse determination on the expedited appeal, you may request a standard appeal or an external appeal. Additional details are provided in following sections.

   B. **Standard Appeals.** You may request an appeal of an adverse decision using our standard appeals process. You may also designate someone to act on your behalf regarding the appeal. You have 180 calendar days from receipt of our initial adverse determination to request an appeal. You may call or write to us to request an appeal. The

notice we send you explains why we made an adverse decision and includes the telephone number you can call to request an appeal.

Once we receive the appeal request, we will obtain a copy of your medical records and send you or your authorized representative an acknowledgement letter within fifteen (15) calendar days of the date we received the request. Our Medical Director, or a physician consultant who is in the same profession and same or similar specialty as the healthcare provider, who typically manages the medical condition or disease or provides the health care service or treatment under review, will review your records. The reviewer will not have been involved in the original decision and will not be a subordinate of the person who made the initial determination.

If information is necessary to conduct a standard appeal, you and your health care provider will be notified, in writing, within ten (10) calendar days of receipt of the appeal, to identify and request the necessary information. We will allow you or your representative ten (10) calendar days from the date of our notice for a pre-service claim and thirty (30) calendar days from our notice on a post-service claim to submit the information requested. If only some of the requested information is submitted, we will make a second request for the missing information in writing, within five (5) business days of receiving the incomplete information. You will be allowed three (3) calendar days from the date of our notice for a pre-service claim and ten (10) calendar days from the date of our notice on a post-service claim to submit the missing information.

We will provide a written decision to you, your representative, and where appropriate, your health care provider within thirty (30) calendar days after receipt of your appeal for pre-service claims and sixty (60) calendar days after receipt of your appeal for post-service claims. In cases where we do not change our original decision, we will also give you the medical reason for the decision. When you receive our final adverse determination, you may request an external review. Additional details are provided in following sections.

The individuals conducting the appeal will fully review the relevant documents, records, and other information. You, your representative, or your provider may submit written comments, documents, records, or other information.

4. **Designating A Representative.** You may designate someone to represent you with regard to your grievance or appeal. If you designate a representative, we will communicate with you and your representative, unless directed otherwise. In order to appoint a representative, you must complete, sign, and return an Authorization Form. This form must be signed and returned before any communication can be sent to the representative. However, in cases involving urgent care, a healthcare professional with knowledge of your medical condition may act as your authorized representative without the need to complete the Authorization Form. You may request this form by calling Member Service at 1-518-220-4600 or toll free at 1-800-888-1238.

5. **Your Grievance and Medical Management Appeal Rights.** Upon written request, and free of charge, you have the right to have access to copies of all documents, records, and other information relevant to your claim. You also have the right to request, in writing, the name of each medical or vocational expert whose advice was obtained in connection with your claim.

   Upon written request, and free of charge, you have the right to an explanation of any scientific or clinical judgment used to deny your claim that applies the terms of your contract, policy, or plan to your medical circumstances.

Upon written request, and free of charge, you have the right to a copy of each rule, guideline, protocol, or similar criteria that was relied upon in making the determination to deny your claim.

You may have the right to bring a civil action under the Employment Retirement Income Security Act of 1974 (ERISA) §502 (a) if you file an appeal or grievance and your request for coverage or benefits is denied following review. You have this right if your coverage is provided under a group health plan that is subject to ERISA.

6. **External Appeals Process.** Upon receipt of a final adverse determination, you have the right to an external appeal of certain coverage determinations made by us. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by New York State and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, member, or healthcare provider associated with the appeal.

   You may have the right to an expedited external appeal if your doctor can attest that a delay in providing the requested service would pose an imminent or serious threat to your health. The time frames for expedited external appeals are shorter than the time frames for standard external appeals. The External Appeals Agent will make a decision within three (3) calendar days for expedited appeals. Every reasonable effort will be made to notify you and the plan of the decision by telephone or fax immediately. This will be followed by a written notice.

   For standard external appeals, the External Appeals Agent will make a decision within thirty (30) calendar days after receipt of your completed application for appeal. Five (5) additional business days may be added if the agent needs additional information. If the agent determines that the information submitted is materially different from that considered by the plan, the plan will have three (3) additional business days to reconsider or affirm its decision. You and the plan will be notified within two (2) business days of the external review agent's decision. The agent must notify you in writing of its decision within two (2) business days.

   In general, you may not request an external appeal unless we have issued a final adverse determination of your request for coverage. The final adverse determination letter will indicate it is a final adverse determination. You may ask us to agree to an external appeal even though you have not completed the internal appeal process and have not obtained a final adverse determination. However, we have no obligation to agree to your request. If we do agree, we will send you a letter stating that we have agreed to an external appeal even though you have not completed the internal appeal process.

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

   A. **Medical Necessity.** You may ask for an external appeal if a requested service has been denied because it has been determined to be medically unnecessary.

   B. **Experimental or Investigational Treatment.** Your attending physician must certify that you have a life-threatening or disabling condition or disease when you request an external appeal for experimental or investigational treatment. 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. To make a recommendation to use experimental or investigational treatment, your attending physician must be board certified or board eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

Additionally, your attending physician must certify that:

- standard health services or procedures have been ineffective or would be medically inappropriate in treating your life-threatening condition or disease; or

- no more beneficial standard treatment exists as a covered service under your health plan, and

- the recommended health service or procedure (including off-label usage of a pharmaceutical product) must be based on at least two documents from the available medical literature.

C. **Clinical Trials.** In order to request an external appeal regarding clinical trials, your attending physician must certify that you have a life-threatening or disabling condition or disease as described under experimental or investigational treatment. Additionally, he or she must certify that a clinical trial for your condition exists and that you are eligible to participate in the clinical trial.

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

   - the National Institutes of Health (NIH), an NIH cooperative group or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs

   - an organization that has been identified by the NIH as a qualified non-governmental research organization; or

   - an Institutional Review Board of a facility that has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

D. **Coverage Based on the External Appeal Agent's Decision.** After you, your representative, or your attending physician applies for an external appeal, an independent External Appeal Agent will review your appeal and make a final determination based on the circumstances of your case

   The External Appeal Agent's decision is final and binding on both parties, your health insurance carrier (us) and the patient (you). In the event that the External Appeal Agent rules in our favor, we will not cover the requested service. If the External Appeal Agent decides in your favor, we will cover the service as follows:

   - for services denied as not medically necessary, we will treat the services as medically necessary and subject to all other conditions of your coverage plan

   - for services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of your coverage plan

   - for services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of your coverage plan. Our coverage doesn't include the cost of the drugs or devices when those items are the subject of the clinical trial.

E. **Requesting an External Appeal.** You or your attending physician may obtain an external appeal application from the State Insurance Department, the Department of Health or by

contacting us. We will send an external appeal application to you when we have made a final adverse determination that is subject to external appeal. The application will provide clear instructions for completion.

To request an external appeal application from the New York State Insurance Department please contact them at the address below:

New York State Insurance Department
One Commerce Plaza
Albany, NY 12257
1-(800) 400-8882
or at their website:
www.ins.state.ny.us
New York State Department of Health
www.health.state.ny.us

You must file your application for an external appeal with the State Insurance Department within forty-five (45) calendar days after receiving a final adverse determination of our appeal process or within forty-five (45) calendar days after receiving a letter from us waiving the internal utilization review appeal process. We do not have the authority to grant extensions of this deadline.

Additional internal plan appeals may be available to you, which are optional. However, regardless of whether you participate in additional internal plan appeals, an application for external appeal must be filed with the New York State Department of Insurance within forty-five (45) calendar days from your receipt of the notice of final adverse determination to be eligible to be reviewed by an external appeal agent.

You will lose your right to an external appeal if you do not file an application for an external appeal within forty-five (45) calendar days from your receipt of the final adverse determination. You must sign an appropriate authorization to release all pertinent medical information concerning your medical condition and request for services.

If you have any questions, please contact our Customer Service Department at:

BlueShield of Northeastern New York
PO Box 15013
Albany, New York 12212
1-518-220-4600or toll free at 1-800-888-1238
Services hours: 8:00 a.m. to 7:00 p.m. Monday - Friday

* Our building is accessible to the handicapped.

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 Your Traditional Blue Rider For Lifetime Maximum Issued By BlueShield of Northeastern New York

This rider amends your current group plan (policy) issued by BlueShield of Northeastern New York pertaining to your lifetime maximum payments by us for in-network and out-of-network benefits.

Lifetime Maximum Payments By Us For In-Network and Out-of-Network Benefits. The benefits in your group plan are not subject to a maximum lifetime limitation.

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

Other Provisions. All of the other provisions contained in your 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

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

This is Your BlueShield of Northeastern New York Rider for Dependent Coverage

In this rider, a "Plan" is defined as any applicable medical, drug, dental, or vision included in your contract. This Rider changes the dependent coverage under your group Plan as follows:

1. **Dependent Children Covered to Age 26.** If your Plan makes coverage of dependents available, this Rider supersedes any other language in your group plan pertaining to dependent ages. This Rider applies to coverage of children as follows:

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

      Coverage for Your Child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attaining age 26 shall not terminate while 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 Your child's attaining age 26.

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

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

   D. Coverage shall be provided for any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate.

2. **Right to Purchase Individual Young Adult Coverage.** 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:

i. request the continuation within sixty days following the date the coverage would otherwise terminate under the "Who is Covered" section of the group plan.

ii. 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, and 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).

iii. 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:

i. the date the young adult no longer meets the requirements of an eligible young adult described in this rider.

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

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

iv. 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 at that time.

3. **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 in this rider.

4. **Other provisions.** All of the terms, conditions, limitations, and exclusions of your BlueShield of Northeastern New York group plan also apply to this rider, except where specifically changed by this rider.

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 Your Traditional Blue Rider for Lifetime Maximum, Annual Maximum, Preventive Services, 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, preventive service payments by us for in-network 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.

- **Preventive Services.** To the extent items and services in the sources referenced below are not already covered benefits for adults and children under your current contract or group plan (policy), the items and services are hereby added to your current contract or group plan (policy):

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

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

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

D. Additional preventive services which are not covered under 3.A, 3.B, or 3.C of this rider, 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.

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.

- **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

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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.

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This Is Your Traditional Blue Amendment to Eliminate Copayment for Pediatric Visits for Dependents Up to Age 19 Issued by BlueShield of Northeastern New York

This amendment changes any language in your current contract, rider, or group plan (policy) issued by BlueShield of Northeastern New York.

1. **Benefits.** A copayment is not required for pediatric visits to a family practitioner, general practitioner, internist, osteopath, or pediatrician; or a certified nurse anesthetist, physician's assistant or nurse practitioner who practices under qualified medical direction and is employed by and practices with a physician as outlined in this rider, in your network for any dependent under the age of nineteen (19) who is covered under your contract or group plan.

   A copay will still apply for a visit to a specialist in your network for any dependent under the age of nineteen (19) who is covered under your contract or group plan.

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

3. **Other Provisions.** All of the other provisions contained in your contract, rider, or 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

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Rider To Your Preferred Provider Group Plan For Out-Of-network Outpatient Treatment of Mental, Nervous, or Emotional Disorders or Ailments

This rider changes your copayment responsibility for outpatient treatment of mental, nervous, or emotional disorders or ailments under your Preferred Provider Group Plan as follows:

1. **Out-Of-Network Outpatient treatment of mental, nervous, or emotional disorders or ailments**. These benefits are subject to the out-of-network deductible and coinsurance terms of your group plan.

2. **New Contract.** The new contract to which you may be entitled if your coverage under your Preferred Provider Group Plan terminates may not contain the benefits provided by this Rider.

3. **Other Provisions**. All of the other provisions contained in your Preferred Provider Group Plan apply to this Rider, except as specifically changed by this Rider.

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Rider To Your Preferred Provider Group Plan For Hospice Visits

This Rider increases coverage for Hospice visits covered under your Preferred Provider Group Plan as follows:

1. **Hospice Visits.** The 210 visit limit for Hospice is removed.

2. **New Contract.** The new contract to which you may be entitled if your coverage under your Preferred Provider Group Plan terminates may not contain the benefits provided by this Rider.

3. **Other Provisions**. All of the other provisions contained in your Preferred Provider Group Plan apply to this Rider, except as specifically changed by this Rider.

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Rider To Your Preferred Provider Group Plan For Out-of-Network Home Care Visits

This Rider increases coverage for out-of-network home care visits covered under your Preferred Provider Group Plan as follows:

1. **Out-of-Network Home Care Visits.** The limit for out-of-network home care visits is removed.

2. **New Contract.** The new contract to which you may be entitled if your coverage under your Preferred Provider Group Plan terminates may not contain the benefits provided by this Rider.

3. **Other Provisions**. All of the other provisions contained in your Preferred Provider 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

Amendment To Your Preferred Provider Group Plan For Immunotherapy for Allergic Disorder Services Copayment

This Amendment changes your copayment responsibility for Allergy Shots (Immunotherapy for Allergic Disorder services) under your Preferred Provider Group Plan as follows.

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

   In-network office based allergy shots are covered in full under your group plan. If your physician provides additional services during the office visit a copayment may be applied for those services.

2. **New Contract.** The new contract to which you may be entitled if your coverage under your Preferred Provider Group Plan terminates may not contain the benefits provided by this Amendment.

3. **Other Provisions**. All of the other provisions contained in your Preferred Provider Group Plan apply to this Amendment, except as specifically changed by this Amendment.

BlueShield of Northeastern New York
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Latham, New York 12110

President & CEO

OPEIU 212 UNION LABEL

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This is your Traditional Blue Amendment For Pre-Hospital Emergency Medical Services Issued By BlueShield of Northeastern New York

This Amendment changes your coverage for Pre-Hospital Emergency Medical Services under your current Group Plan and/or riders, as follows.

1. **Pre-Hospital Emergency Medical Services**. We will extend coverage to include medically necessary pre-hospital emergency medical services for airborne ambulance transportation to a hospital from the scene of the accident or illness. Our payment will be made in accordance with the provisions of your group plan and/or rider.

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

3. **Other Provisions**. All of the other provisions contained in your Group Plan apply to this Amendment, except as specifically changed by this Amendment.

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This Is Your Women's Health and Cancer Rights Act (WHCRA) Endorsement Issued By BlueShield of Northeastern New York

This endorsement changes any language in your current group plan, contract or rider.

1. **Women's Health and Cancer Rights Act.** In addition to the women's Health and Cancer services covered as described in you group plan or contract, your benefits include treatment of physical complications of mastectomy, including lymphedema in a manner determined in consultation with the attending provider and the patient.

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

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

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This Is Your Traditional Blue Amendment for the Treatment of Mental, Nervous, Emotional Disorders or Ailments, and Chemical Abuse or Chemical Dependence

This amends the benefits under your contract or group plan for the treatment of mental, nervous, emotional disorders or ailments, and chemical abuse or chemical dependence. Mental Health Care means medically necessary care rendered by an eligible practitioner or approved facility and which, in the opinion of our medical director, is directed predominantly at treatable behavioral manifestations of a condition that we determine: (a) is a clinically significant behavioral or psychological syndrome pattern, illness or disorder; (b) substantially or materially impairs a person's ability to function in one or more major life activities; and (c) has been classified as a mental disorder in the current American Psychiatric Association Statistical Manual of Mental Disorders. Chemical abuse shall mean and include alcohol and substance abuse. Chemical dependence shall mean and include alcoholism and substance dependence. This rider is issued as an additional part of your contract or group plan (policy) issued by BlueShield of Northeastern New York.

1. **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 unlimited days of coverage, per person per plan year, for the active treatment of mental, nervous, or emotional disorders or ailments, if it is Medically Necessary in the judgment of your physician and our Medical Director. Active treatment means treatment furnished in conjunction with inpatient confinement for mental, nervous, emotional disorders or ailments that meet such standards as shall be prescribed pursuant to the regulations of the Commissioner of Mental Health. Services covered under this section, rendered by a participating provider, are subject to the inpatient cost sharing arrangement according to your contract or group plan. Services received out of network, or by a non-participating provider, are subject to the deductible and coinsurance according to your contract or group plan.

2. **Inpatient Rehabilitation Care for Chemical Abuse.** We will provide unlimited days of coverage, 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. Services covered under this section, rendered by a participating provider, are subject to the inpatient cost sharing arrangement according to your contract or group plan. Services received out of network, or by a non-participating provider, are subject to the deductible and coinsurance according to your contract or group plan.

3. **Inpatient Detoxification Care for Chemical Dependence.** We will provide unlimited days of coverage for acute inpatient hospitalization, per person per plan year, 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. Services covered under this section, rendered by a participating provider, are subject to the inpatient cost sharing arrangement according to your contract or group plan. Services received out of network, or by a non-participating provider, are subject to the deductible and coinsurance according to your contract or group plan.

4. **Outpatient and Office Based Treatment of Mental, Nervous, or Emotional Disorders or Ailments and Chemical Abuse or Chemical Dependence.** We will provide unlimited days of coverage, per person per plan year, for visits in connection with the diagnosis and treatment of mental, nervous, or emotional disorders or ailments and chemical abuse or chemical dependence provided to you on an outpatient basis in your Participating Physician's or Provider's office, by a psychiatrist or psychologist licensed to practice in this state, or a professional corporation or university faculty practice corporation thereof. We will also provide coverage for unlimited visits for bereavement counseling services to your family, either before or after your death in the event you are being cared for in a Hospice setting. 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: (A.) three or more 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 (B.) three or more years post degree experience in psychotherapy under the supervision, satisfactory to the state board for social work, of a psychiatrist, a licensed and 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. Services covered under this section, rendered by a participating provider, are subject to a $0 copay . Services received out of network, or by a non-participating provider, are subject to the deductible and coinsurance according to your contract or group plan.

5. **Outpatient Facility Based Treatment of Mental, Nervous, or Emotional Disorders or Ailments.** We will provide unlimited days of coverage, per person per plan year, for visits in connection with the diagnosis and treatment of mental, nervous, or emotional disorders or ailments provided to you on an outpatient basis by a facility issued an operating certificate by the New York State Commissioner of Mental Health pursuant to Article 31 of the New York State Mental Hygiene Law or in a facility operated by the New York State Office of Mental Health. Services covered under this section, rendered by a participating provider, are subject to a $0 copay. Services received out of network, or by a non-participating provider, are subject to the deductible and coinsurance according to your contract or group plan.

6. **Outpatient Treatment of Chemical Abuse and Chemical Dependence.** We will provide unlimited days of coverage, per person, per plan year for outpatient visits in connection with the diagnosis and treatment of chemical abuse and chemical dependence as described in your contract or group plan. Coverage is limited to participating 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. Services covered under this section, rendered by a participating provider, are subject to a $0 copay. Services received out of network, or by a non-participating provider, are subject to the deductible and coinsurance according to your contract or group plan.

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 have not charged you if you were not covered by insurance.

7. **Intensive Outpatient Program and Partial Hospitalization Program for Mental, Nervous, Emotional Disorders or Ailments, and Chemical Abuse or Chemical Dependence.** We will provide unlimited days of coverage, per person per plan year, for alternative treatment programs in connection with the diagnosis and treatment of mental, nervous, emotional disorders or ailments, and chemical abuse or chemical dependence provided to you on an outpatient basis in your Participating Physician's or Provider's office or by a facility issued an operating certificate by the New York State Commissioner of Mental Health pursuant to Article 31 of the New York State Mental Hygiene Law, in a facility operated by the New York State Office of Mental Health, by a psychiatrist or psychologist licensed to practice in this state, or by a professional corporation or university faculty practice corporation thereof. 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: (A.) three or more 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 (B.) three or more years post degree experience in psychotherapy under the supervision, satisfactory to the state board for social work, of a psychiatrist, a licensed and 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.

   a. **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. Services covered in an intensive outpatient program are subject to a $0 copay , per intensive outpatient treatment visit.

   b. **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, substance abuse facility, or hospital. When receiving partial hospitalization mental health and chemical abuse or chemical dependence services, you will be required to pay a $0 copay for each visit.

   c. Services received out of network, or by a non-participating provider, are subject to the deductible and coinsurance according to your contract or group plan for each visit.

8. **Out of Pocket Maximum.** Payments made for covered mental health, chemical abuse, or chemical dependence services will apply toward the applicable plan year, out-of-pocket payment requirement according to your contract or group plan. Once the plan year

out-of-pocket payment maximum has been satisfied, there will be no further out-of-pocket expense for covered services for the remainder of the plan year.

9. **Exclusions.** We will not provide coverage for care in a non-therapeutic residential facility for any of the benefit classifications listed above. The treatment must be provided by trained, professional personnel. We will not provide coverage for days of care which consist primarily of participation in programs of a social, recreational, or companionship nature. Your admission must be authorized by your Physician, and you must remain under the care of your Physician while you are being treated.

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

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

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President & CEO

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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 copayment 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 copayment 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

OPEIU 212
UNION LABEL

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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.

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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 $20 copayment toward the cost of an eye examination.

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

B. **Covered Services from Non-Participating Providers.** If you receive services from a provider who does not have a written agreement with us, or a delegated entity, regarding payment for covered services (a "Non-Participating Provider"), benefits will be paid based on the fee schedule allowance for the service. However, the Non-Participating Provider may charge his/her usual fee for covered or non-covered services. You are responsible for the copayment applicable to a participating provider plus the difference between the amount of our payment and the Non-Participating Provider's actual charge.

To request reimbursement for covered services received from Non-Participating Providers a completed Non-Participating Provider claim form must be mailed to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

The completion and submission of this form does not guarantee eligibility for benefits.

C. **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.

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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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