NEW YORK STATE TEAMSTERS COUNCIL HEALTH & HOSPITAL FUND

MEDICAL BENEFITS PLAN

Effective June 1, 2025

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MEDICAL BENEFITS PLAN

The Medical Benefits Plan ("Plan") is self-funded by the New York State Teamsters Council Health & Hospital Fund ("Fund") and administered by Excellus BlueCross BlueShield, Central New York Region:

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The New York State Teamsters Council Health and Hospital Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 315-455-9790 or toll free at 1-877-698-3863. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SECTION 1

ELIGIBILITY RULES FOR NEW PARTICIPANTS AND NEW EMPLOYERS

Eligibility for Medical Benefits provided by the Fund is determined by the Fund in accordance with the Fund's Eligibility Rules, which are contained in the General Eligibility & ERISA Rights Information booklet provided by the Fund.

SECTION 2

MEDICAL BENEFITS PLAN OPTIONS/PREFERRED PROVIDER NETWORK

Medical Benefits Plan Options

The Medical Benefits Plan options available under the Plan are.

Option 1: Supreme Benefits

Option 2: Select Benefits

Option 3: Classic Benefits

Option 4: Royale Benefits

Option 5: High Deductible Plan with an HRA

The Medical Benefits Plan Option that applies to you and your dependents is determined by the contribution rate paid to the Fund and the Benefit Selection Form signed by your employer and your local union. If you have any questions concerning the Medical Benefits Plan Option that applies to you and your dependents, you may contact the Fund Office.

A Schedule of Benefits describing the benefits available to you is attached as Appendix A. The Schedule of Benefits may contain limitations and/or conditions on the availability of the benefits described in this booklet. Please refer to the Schedule of Benefits when considering whether limitations or conditions apply to a particular benefit.

Preferred Provider Network

The Supreme, Select, Classic and Royale Benefits are provided through a Preferred Provider Organization ("PPO") product administered by Excellus BlueCross BlueShield ("EBCBS") to provide medical benefits. Hospitals and other Professional Providers who participate in the PPO are referred to as "In Network." Hospitals and other Professional Providers who do not participate are referred to as "Out-of-Network".

Where services are rendered in the area of a BlueCross BlueShield organization other than EBCBS, the benefit payable under the Plan will depend on whether the Provider participates in the local BlueCross BlueShield PPO Network. Any In-Network Provider cannot "balance bill"

the Plan participants for any amounts greater than your local BlueCross BlueShield payment amount.

You are free to choose your own hospital and your own doctor. There are no restrictions as long as you use a licensed hospital and a licensed physician. However, if you use an Out-of-Network Provider that does not participate in your local PPO Network, you will likely incur a greater level of out of pocket cost than if you had used an In-Network provider.

Unless otherwise specifically provided herein, the Allowable Expense for payment of out-of-network claims will be determined by the Plan based on the lowest of (1) the hospital or other professional provider's charge, (2) The amount approved by the local Blue Cross Blue Shield Plan [with whom the provider has an agreement], or (3) the average amount Blue Cross Blue Shield of CNY has negotiated with its participating providers for the type of care you receive, based on a regional fee schedule.

SECTION 3

DEFINITIONS

1. Definitions.

A. Allowable Expense. "Allowable Expense" means the maximum amount the Plan will pay to a Facility, Professional Provider or Provider of Additional Health Services for the services or supplies covered under the Plan before any applicable Deductible, Copayment and Coinsurance amounts are subtracted.

The "Allowable Expense" for In-Network Providers will be the amount Excellus BlueCross BlueShield ("EBCBS") has negotiated with the In-Network Provider or the In-Network Provider's charge, whichever is less. However, when the In-Network Provider's charge is less than the amount EBCBS has negotiated with the In-Network Provider, your Coinsurance, Copayment or Deductible amount will be based on the In-Network Provider's charge.

Unless otherwise specifically provided herein, the "Allowable Expense" for Out-of-Network Providers will be determined by the Plan based on the lowest of (1) the Out-of-Network Provider's charge, (2) the amount approved by the local Blue Cross Blue Shield Plan with whom the Out-of-Network Provider has an agreement, or (3) the average amount EBCBS has negotiated with its participating providers for the type of care you receive, based on a regional fee schedule. The Out-of-Network Provider's actual charge may exceed the Allowable Expense. For anything other than Surprise Bills, you must pay the difference between the Allowable Expense and the Out-of-Network Provider's charge.

Ground Ambulance. The "Allowable Expense" for an Out-of-Network Provider for ground ambulance, other than ground ambulance that may be considered as part of a Surprise Bill, will be the Out-of-Network Provider's charge.

Surprise Bills. The "Allowable Expense" for Surprise Bills for an Out-of-Network Provider will be the lesser of the Out-of-Network Provider's charge or the "Qualifying Payment Amount." See the section titled "Protection from Surprise Bills" below for what constitutes a Surprise Bill and how the Qualifying Payment Amount is determined.

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

B. Biologically-Based Mental Illness. A mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Biologically-based mental illnesses are defined as the following:

(1) Schizophrenia/psychotic disorders;
(2) Major depression;
(3) Bipolar disorder;
(4) Delusional disorders;
(5) Panic disorder;
(6) Obsessive compulsive disorder;
(7) Bulimia; and
(8) Anorexia.

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

D. Children with Serious Emotional Disturbances. Persons under the age of 18 years who have diagnoses of attention deficit disorders, disruptive behavior disorders or pervasive development disorders, **and** where one or more of the following are present:

(1) Serious suicidal symptoms or other life-threatening self-destructive behaviors;

(2) Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);

(3) Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or

(4) Behavior caused by emotional disturbances that placed the child at significant risk of removal from the household.

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

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

G. **Deductible.** A charge, expressed as a fixed dollar amount that you must pay once each Year before we will pay anything for Out-of-Network Benefits covered under this Plan during that Year.

H. **Emergency Condition.** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in the Emergency Medical Treatment and Active Labor Act ("EMTALA"), including: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

H.1 **Emergency Services**. With respect to an Emergency Condition, a medical screening examination (as required under EMTALA or as would be required under EMTALA if it applied to an Independent Freestanding Emergency Department) which is within the capability of the emergency department of a Hospital (or Independent Freestanding Emergency Department), including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital (or Independent Freestanding Emergency Department) and such further medical examination and treatment as are required to stabilize the patient, regardless of the department of the Hospital in which further examination or treatment is furnished.

"Emergency Services" also include certain post-stabilization services, unless the following conditions are met:

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

(2) If the Provider is an Out-of-Network Provider, (a) the Provider gives you notice that the services rendered will be performed by an Out-of-Network Provider and you consent to waive your rights under the surprise bill requirements, and (b) you or your authorized representative are in a condition to provide informed, voluntary consent; and

(3) The Provider satisfies any additional applicable laws and requirements including, without limitation, those provided in guidance issued by the Department of Health and Human Services.

I. **Facility.** A Hospital; ambulatory surgery facility; birthing center; dialysis center; rehabilitation facility; Skilled Nursing Facility, hospice; home health agency or home care services agency; an institutional provider of mental health or chemical dependence and abuse treatment; or other provider. If you receive treatment for chemical dependence or abuse outside of New York State, the Facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JACHO") to provide a chemical abuse treatment program.

J. **Gene Therapy.** Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. The Fund does not cover any charges related to gene therapy, regardless of whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered experimental or investigational. Examples of gene therapy include, but are not limited to, Zolgensma, Luxterna, and Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta.

K. **Hospital.** Any short-term acute general hospital facility that is accredited as a hospital and is certified under Medicare. A Hospital is a licensed institution primarily engaged in providing:

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

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

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

None of the following are considered Hospitals:

(1) Hospitals for treatment of mental illness. If you are a patient in a separate division or unit of a Hospital dedicated to the treatment of mental illness where the average length of stay is more than 30 days, that separate division or unit is not considered a Hospital;

(2) Places primarily for nursing care;

(3) Skilled Nursing Facilities;

(4) Convalescent homes or similar institutions;

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

(6) Health resorts; spas; or sanitariums;

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

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

(9) Free standing ambulatory surgical centers.

K.1 **Independent Freestanding Emergency Department**. A health care facility that provides Emergency Services and is geographically separate and distinct and licensed separately from a Hospital under applicable state law.

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

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

(1) Name, address, and telephone number;

(2) Specialty;

(3) Board certification (if applicable);

(4) Languages spoken; and

(5) Whether the In-Network Provider is accepting new patients.

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

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

(1) The provider is listed as an In-Network Provider in the online provider directory;

(2) The paper provider directory listing the provider as an In-Network Provider is incorrect as of the date of publication;

(3) You were given written notice that the provider is an In-Network Provider in response to your telephone request for network status information about the provider; or

(4) You are not provided with written notice within one business day of your telephone request for network status information.

N. **Medical Necessity.** See Section 4, page 8.

O. **Member.** Any Participant or eligible dependent who meets all applicable eligibility requirements and who is covered under this Plan.

P. **Mental Illness.** A mental, nervous or emotional condition that we determine has treatable behavioral manifestations and that we also determine:

(1) Is a clinically significant alteration in thinking, mood or behavior, or a combination thereof; and

(2) Substantially or materially impairs your ability to function in one or more major life activities; and

(3) Has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

Q. **Out-of-Network Benefits.** The Out of-Network Benefits portion of this Plan covers health care services described in this Plan when you receive the covered services from an Out-of-Network Provider. When you receive Out-of-Network Benefits, you will incur out-of-pocket expenses. You will be responsible for meeting an annual Deductible and for paying a Coinsurance amount as well as paying any difference between the Allowable Expense and the provider's charge.

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

S. **Plan.** The benefits and provisions described in this document.

T. **Plan Administrator.** The Plan Administrator is the Board of Trustees of the Fund, who are fiduciaries of the Plan. The Board of Trustees has all discretionary authority to interpret the provisions and control the operation and administration of the Plan.

U. **Precertification.** The process of reviewing the necessity, appropriateness, location, duration and/or cost efficiency of a health care service before it is rendered.

V. **Preferred Provider Organization (PPO).** A network of Facilities, Professional Providers and Providers of Additional Health Services that have provider agreements with a Blue Cross and/or Blue Shield Plan to provide health services to Members.

W. **Professional Provider.** A certified and licensed physician; osteopath; dentist; optometrist; chiropractor; registered psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; licensed midwife; speech-language pathologist; audiologist; or any other licensed health care provider.

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

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

Z. **Skilled Nursing Facility.** A facility accredited as a Skilled Nursing Facility or qualified as a Skilled Nursing Facility under Medicare.

AA. **Year.** The 12-month period on which the Deductible and Coinsurance and any annual limits under this Plan are based. Unless otherwise indicated, the 12-month period is the Calendar Year as defined above.

SECTION 4

MEDICAL NECESSITY AND PRIOR AUTHORIZATION

1. Care Must Be Medically Necessary. The Plan will provide coverage for the covered benefits described in the Booklet as long as the hospitalization, care, service, technology,

test, treatment, drug or supply (collectively, "Service") is Medically Necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the Service does not make it Medically Necessary or mean that the Fund must provide coverage for it.

Services will be deemed Medically Necessary only if:

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

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

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

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

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

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

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

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

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

A. all services relating to organ and tissue transplants;

B. all In-Network benefits and Out-of-Network Benefits for inpatient admissions, including maternity admissions;

C. all Skilled Nursing Facility admissions;

D. all Home Care services.

4. **Prior Approval Procedure.** Members who seek coverage for the services listed in Paragraph 3 above must call Excellus at the number indicated on their identification card to have the care pre-approved. We request that you call at least seven days prior to a planned inpatient admissions. If you are hospitalized in cases of an Emergency Condition involving any of these services, you should call Excellus within 24 hours after your admission or as soon thereafter as reasonably possible. However, you must call us as soon as it is reasonably possible in order for any follow-up care to be covered. The availability of an organ for transplantation resulting in the necessity for an immediate admission for implantation shall be considered an Emergency Condition for purposes of this paragraph. After receiving a request for approval, Excellus will review the reasons for your planned treatment and determine if benefits are available. Excellus will notify you and your Professional Provider of its decision by telephone and in writing within three business days of receipt of all necessary information. If your treatment involves continued or extended health care services, or additional services for a course of continued treatment, Excellus will notify you and your Professional Provider within one business day of receipt of all necessary information.

5. **Failure to Seek Approval.** If you fail to seek prior approval for benefits subject to this Section, the Plan will pay an amount $500 less than it would otherwise have paid for the care, or the Plan will pay only 50% of the amount that would otherwise have been paid for the care, whichever results in a greater benefit for you. You must pay the remaining charges. The Plan will pay the amount specified above only if it is determined that the care was Medically Necessary even though you did not seek prior approval. If it determined, in sole judgment of the Plan Administrator, that the services were not Medically Necessary, you will be responsible for paying the entire charge for the service.

6. **Courtesy Authorization**. While not required prior to receiving the services, you may ask your physician to contact Excellus to confirm that a certain procedure or service will be covered by the Plan. For example, prior to undergoing a PET scan, you may request your physician to contact Excellus to determine whether it is covered as medically necessary.

SECTION 5

COST SHARING EXPENSES

1. **Copayments.** The copayments you must pay for covered services when you are entitled to In-Network Benefits are set forth in the Schedule of Benefits attached as Appendix A.

2. **Deductible.** The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. Once the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that year. The annual individual and family deductible amounts are shown in the Schedule of Benefits attached as Appendix A.

3. **Coinsurance.** Except where stated otherwise, after you have satisfied the annual Deductible described above, you will be responsible for a percentage of the Allowable Expense. The Coinsurance amounts you must pay are set forth in the Schedule of Benefits attached as Appendix A.

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

5. **Out-of-Pocket Maximum.** An out-of-pocket maximum is the maximum amount of coinsurance payable for covered expenses each covered individual must pay during a year, excluding the Deductible and Copayments. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of additional covered expenses for the remainder of that year. The annual Out of Pocket Maximum is shown on the Schedule of Benefits attached as Appendix A.

SECTION 5A

PROTECTION FROM SURPRISE BILLS

A 'Surprise Bill' is a bill you receive for a covered service in the following circumstances:

(1) Emergency Services performed by an Out-of-Network Provider with respect to an Emergency Condition;

(2) Air ambulance services performed by an Out-of-Network Provider; and

(3) For certain non-Emergency Services performed by an Out-of-Network Provider at a participating Hospital, ambulatory surgical center and Independent Freestanding Emergency Department.

There are special reimbursement rules that apply to Surprise Bills when determining the Plan's payment to the Out-of-Network Provider. These special reimbursement rules will always apply to the following covered non-Emergency Services when performed by an Out-of-Network Provider at an In-Network Hospital, ambulatory surgical center or Independent Freestanding Emergency Department:

(1) Covered services performed by an Out-of-Network Provider when an In-Network Provider is unavailable at the time the healthcare services are performed at the In-Network Hospital, ambulatory surgical center or Independent Freestanding Emergency Department;

(2) Covered services performed by an Out-of-Network Provider as a result of unforeseen, urgent medical issues that arise at the time such services are

performed, even if you previously consented to the Out-of-Network Provider performing such services;

(3) Covered services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;

(4) Covered services provided by assistant surgeons, hospitalists, and intensivists; and

(5) *Diagnostic services, including radiology and laboratory services*. A Surprise Bill does not include a bill for healthcare services when an In-Network Provider is available and you elected to receive services from an Out-of-Network Provider or, with respect to non-Emergency Services (other than those specified above) performed by an Out-of-Network Provider in a participating Hospital, ambulatory surgical center or Independent Freestanding Emergency Department if the Out-of-Network Provider has obtained your consent to receive the services after providing you with required notice and satisfying all other consent requirements applicable to the Out-of-Network Provider. If the Out-of-Network Provider follows the notice and consent requirements and you consent to receiving the services, the Plan's normal reimbursement rules with respect to Out-of-Network Providers will apply with regard to those services and you may be balance billed. Please see the definition of 'Allowable Expense' for information about the Plan's normal reimbursement rules.

For Surprise Bills, the Plan will reimburse the Out-of-Network Provider an initial payment equal to the Recognized Amount. You will be held harmless for any Out-of-Network Provider charges for the Surprise Bill that exceed your cost-sharing under the Plan (i.e., Copayment, Deductible or Coinsurance) for In-Network Providers. Your cost-sharing will be calculated based off of the Recognized Amount and will count towards your In-Network Deductible, if any, and your In-Network Out-of-Pocket Maximum.

For purposes of this Section, the 'Recognized Amount' means the lesser of the billed charges or the 'Qualifying Payment Amount.' The 'Qualifying Payment Amount' is the amount determined by the Plan in accordance with the requirements of 29 CFR 2590.716-3.

The provisions specified in this Section and in the Plan are designed to comply with the group health plan requirements of the No Surprises Act. The provisions are based on regulations published by the U.S. Department of the Treasury, Department of Labor, and Department of Health and Human Services (the "Departments") and will be interpreted to be consistent with those regulations. If the Departments issue additional guidance regarding the requirements of the No Surprises Act, the Plan will comply with the additional or modified requirements as required by such guidance.

To the extent the Plan provides coverage for air ambulance or Emergency Services for an Emergency Condition and the cost-sharing applied to such air ambulance services or Emergency Services when rendered by an Out-of-Network Provider is different than the cost-sharing applied when such services are rendered by an In-Network Provider, to the extent necessary to comply

with the No Surprises Act, the Plan will apply the same cost-sharing to air ambulance services or Emergency Services for an Emergency Condition when rendered by an Out-of-Network Provider as the cost-sharing that is applied to such services when rendered by an In-Network Provider.

SECTION 5B

TRANSITIONAL CARE

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

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

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

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

(1) You are undergoing a course of treatment for a 'serious and complex condition.' For this purpose, 'serious and complex condition' means:

a. An acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

b. A chronic illness that is life threatening, degenerative, potentially disabling or congenital and requires specialized medical care for a prolonged period of time.

(2) You are undergoing a course of institutional or inpatient care from the provider.

(3) You are scheduled to undergo non-elective surgery, including post-operative care from the provider.

(4) You are pregnant and undergoing a course of treatment for the pregnancy from the provider.

(5) You are terminally ill (as defined in Section 1861 of the Social Security Act) and receiving treatment for the terminal illness from the provider.

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

If you have any questions with respect to this section, please contact EBCBS at the telephone number listed on your identification card.

SECTION 6

INPATIENT CARE

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

2. **Services Not Covered.** We will not provide coverage for:

A. Additional charges for special duty nurses;

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

C. Blood, except we will provide coverage for blood required for the treatment of hemophilia. However, we will provide coverage for blood and blood products when participation in a voluntary blood replacement program is not available to you;

D. Non-medical items, such as telephone or television rental;

E. Medications, supplies, and equipment which you take home from the Facility; or

F. Custodial care.

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

A. **Inpatient Hospital Care.** We will provide coverage when you are required to stay in a Hospital for acute medical or surgical care and are not admitted to the hospital for mental health care or for diagnosis and treatment of chemical dependence and/or abuse. We will provide coverage for any day on which it is Medically Necessary for you to receive inpatient care.

B. **Mental Health Care.** We will provide coverage for diagnosis and treatment of Mental Illness in a hospital as defined by subdivision ten of section 1.03 of the New York Mental Hygiene Law. The term "active treatment" means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meets standards prescribed pursuant to the regulations of the Commissioner of Mental Health.

We will also provide coverage for care in a licensed partial hospitalization program. A partial hospitalization program is an ambulatory treatment program that provides a medically supervised alternative to inpatient treatment.

The coverage described above includes benefits for Biologically-Based Mental Illness and for Children with Serious Emotional Disturbances.

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

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

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

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

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

E. **Physical Rehabilitation.** We will provide coverage for comprehensive physical medicine and rehabilitation (chemical dependence and abuse programs are excluded) for a condition that in the judgment of your Professional Provider can reasonably be expected to result in significant improvement within a relatively short period of time.

F. **Inpatient Chemical Dependence and Abuse Rehabilitation.** We will provide coverage for the diagnosis and active treatment for rehabilitation of chemical dependence and abuse. We will provide covered services for a 24-hour live-in program of services in a Facility that is a Plan-approved provider for the active rehabilitation and treatment of chemical abuse. The program is non-medical and provides rehabilitation and treatment for chemical abuse or dependence in a controlled environment. We will not provide benefits for care in a non-therapeutic residential facility.

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

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

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

7. **Observation Stay.** We will provide coverage for observation services for up to 23 hours observation. Services are: furnished in the outpatient department of a Facility; and are in lieu an inpatient admission. The services include: use of a bed and periodic monitoring

by nursing or other licensed staff that is reasonable and necessary to evaluate the patient's condition or determine the need for an inpatient admission.

SECTION 7

OUTPATIENT CARE

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

1. **Care In Connection With Surgery.** We will only provide coverage if we determine that it was Medically Necessary to use the Facility to perform the surgery.

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

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

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

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

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

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

4. **Laboratory And Pathology Services.** We will provide coverage for diagnostic and routine laboratory and pathology services.

5. **Radiation Therapy.** We will provide coverage for radiation therapy.

6. **Chemotherapy.** We will provide coverage for chemotherapy.

7. **Dialysis.** We will provide coverage for dialysis treatments of an acute or chronic kidney ailment.

8. **Mental Health Care**. We will provide benefits for diagnosis and treatment of Mental Illnesses.

The coverage described above includes benefits for Biologically-Based Mental Illness and for Children with Serious Emotional Disturbances.

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

10. **Covered Therapies**. We will provide coverage for related rehabilitative physical therapy and physical, occupational and speech therapy when services are rendered by a licensed physical therapist, occupational therapist or speech language pathologist or audiologist and when we determine that your condition is subject to significant clinical improvement through relatively short-term therapy.

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

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

13. **Injectable Drug Copayments**. When drugs are administered by injection during the course of an outpatient visit covered under this section, you are responsible for a Copayment for the drug(s). The drug Copayment is in addition to the Copayment, if any, that applies to the outpatient visit.

14. **Telemedicine Program.** Participants and their eligible dependents enrolled in the Medical Benefits Plan may utilize the Excellus BlueCross BlueShield Telemedicine Program for appropriate covered services. The Program provides on-demand or by appointment doctor visits by telephone or web-based video with participating physicians for non-emergency medical conditions. Physician specialties include primary care, pediatrics, and family medicine. The Telemedicine Program can be accessed 24 hours a day, 7 days a week. As a participant, you will receive information regarding how to register for the Program and, once registered, how to utilize the Program. You will not be charged for a Telemedicine visit under this Program for covered services so long as you are registered, and the vendor is able to confirm your coverage at the point of service. For more information, please contact the Fund Office.

SECTION 8

HOME CARE

1. **Type of Home Care Provider**. We will provide coverage for home care visits given by a certified home health agency or licensed home care services agency if your Professional Provider determines that the visits are Medically Necessary.

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

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

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

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

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

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

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

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

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

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

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

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

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

5. **Number of Visits**. We will provide coverage beginning with the first day on which care is provided.

SECTION 9

HOSPICE CARE

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

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

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

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

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

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

B. Day care services provided by the hospice organization;

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

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

(2) Physical therapy;

(3) Speech therapy;

(4) Occupational therapy;

(5) Respiratory therapy;

(6) Social services;

(7) Nutritional services;

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

(9) Medical supplies;

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

(11) Durable medical equipment; and

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

D. Medical care provided by a physician.

4. **Number of Visits**. We will provide coverage for unlimited days of hospice care, beginning with the first day on which care is provided. Each day you receive care from or through the hospice counts as a day of hospice care. We will also provide coverage for up to five visits for bereavement counseling services to your family, either before or after your death.

SECTION 10

PROFESSIONAL SERVICES

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

1. **Surgery**. Surgery includes operative procedures for the treatment of disease or injury. It includes any pre and post-operative care usually rendered in connection with such procedures. Pre-operative care includes pre-operative examinations that result in a decision to operate. Surgery also includes endoscopic procedures and the care of fractures and dislocations of bones. We will also provide coverage for surgical services including all stages of reconstructive surgery on a breast on which a mastectomy has been performed. We will also provide coverage for reconstructive surgical procedures on the other breast to produce a symmetrical appearance. We will also provide coverage for prostheses and treatment of physical complications of a mastectomy, including lymphedemas. Coverage will be provided for all such services rendered in the manner determined appropriate by you and your Professional Provider.

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

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

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

2. **Covered Therapies**. We will provide coverage for related rehabilitative physical, occupational and speech therapy when services are rendered by a licensed physical therapist, occupational therapist or speech language pathologist or audiologist and when we determine that your condition is subject to significant clinical improvement through relatively short-term therapy.

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

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

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

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

(1) Who is a board certified specialist; and

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

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

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

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

5. **Second Medical Opinions**. We will provide coverage for an office visit in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer. A positive diagnosis of cancer occurs when you are diagnosed by your Professional Provider as having some form of cancer. A negative diagnosis of cancer occurs when your Professional Provider performs a cancer-screening exam on you and finds that you do not have cancer, based on the exam results. We will also provide

coverage for a second medical opinion concerning any recommendation of a course of treatment of cancer. The second medical opinion must be rendered by an appropriate specialist, including but not limited to, a specialist associated with a specialty care center for the treatment of cancer. You will be entitled to In-Network Benefits when your Professional Provider provides a written referral to an Out-of-Network Professional Provider.

6. Maternity Care (BENEFITS AVAILABLE ONLY FOR PARTICIPANT AND SPOUSE; NO BENEFITS FOR DEPENDENT CHILDREN – SEE EXCLUSION #21). We will provide coverage for:

A. **Normal Pregnancy.** Maternity care includes the first visit upon which a positive pregnancy test is determined. It also includes all subsequent prenatal and postpartum care. These benefits include the services of a licensed midwife, under qualified medical direction, affiliated or practicing in conjunction with a licensed Facility. We will also provide coverage for the following for pregnant women:

- Asymptomatic Bacteriuria Screening (UTI)
- RH (D) Incompatibility Screening
- Daily folic acid supplements for women capable of becoming pregnant
- Hepatitis B Virus Infection, Screening
- Breastfeeding, Primary Care Interventions to Promote
- Iron Deficiency, Anemia, Prevention – Screening
- Sexually Transmitted Infections Counseling
- STD Testing based on risk (other than Chlamydia, HIV)
- Syphilis Infection Screening

B. **Complications of Pregnancy and Termination**. We will provide coverage for complications of pregnancy and for terminations of pregnancy.

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

7. **Inpatient Medical Services**. We will provide coverage for medical visits by a Professional Provider on any day of inpatient care covered under this Plan. We will not provide coverage for medical visits by Facility employees or interns, even if they are Professional Providers. The Professional Provider's services must be documented in the Facility records. We will cover only one visit per day per Professional Provider. However, services rendered by up to two Professional Providers on a single day will be covered if the two Professional Providers have different specialties and are treating separate conditions.

8. **Preventive Care Benefits for Adults**. We will provide coverage for the following preventive care services for adults whether performed in a Facility or in a Professional Provider's office:

- Abdominal Aortic Aneurysm Screening in men aged 65 – 75
- Adult Immunizations
- Alcohol Misuse Screening & Behavioral Counseling Interventions

- Bone Density (Osteoporosis) for women
- Breast and Ovarian Cancer Susceptibility & Genetic Risk Assessment and BRCA Mutation Testing
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening for women and pregnant women
- Colorectal Cancer Screening – Colonoscopy, Signomoidoscopy, Laboratory & Pathology
- Depression Screening
- Diabetes screening
- Diet, Behavioral Counseling in Primary Care to promote a healthy diet – Dietician & Physician
- Gonorrhea & Screening for women and pregnant women
- High Blood Pressure screening
- HIV Screening
- Lipid Screening
- Obesity Screening
- Sexually Transmitted Infections, counseling for at risk populations
- Syphilis Infection Screening in at-risk populations
- Tobacco Use and Tobacco-Caused Disease Counseling

9. **Preventive Care Benefits for Newborns and Children**. We will provide coverage for the following preventive care services for newborns and children whether performed in a Facility or in a Professional Provider's office:

- Congenital Hypothyroidism Screening in newborns
- Dental Caries in Preschool Children, Prevention
- Major Depressive Disorder in Children and adolescents, Screening
- Gonorrhea, Prophylactic Medication for newborns
- Hearing Loss, Newborns
- Iron Supplements for at-risk infants 6 – 12 months
- Phenyketonuria Screening in newborns
- Screening and interventions for childhood obesity
- Sickle Cell Disease Screening in newborns
- Tuberculosis screening for at risk children
- Visual Impairment in Children younger than age 5 years, Screening

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

A. **Routine Physical Examinations**. We will provide coverage for periodic adult routine physical examinations in accordance with a schedule based on national coverage determinations, but not to exceed one examination per Member, per Year.

B. **GYN Examinations**. We will provide coverage for diagnostic and routine gynecological examinations. We will provide coverage for one routine examination per Member, per Year.

C. **Well Child Visits and Immunizations**. We will provide coverage for well child visits in accordance with the schedule recommended by the American Academy of Pediatrics. We will also cover childhood immunizations recommended by the Advisory Committee on Immunization Practices ("ACIP"), in accordance with the ACIP recommended schedule. We will cover services typically provided in conjunction with a well-child visit. Such services include at least: complete medical histories; a complete physical exam; developmental assessments; anticipatory guidance; laboratory tests performed in the practitioner's office or in a clinical laboratory; and/or other services ordered at the time of the well child visit.

D. **Laboratory and Pathology Services**. We will provide coverage for diagnostic and routine laboratory and pathology services.

E. **Vision Examinations**. We will provide coverage for diagnostic vision examinations.

F. **Hearing Examinations**. We will provide coverage for diagnostic and routine hearing examinations and evaluations. We will provide coverage for routine hearing evaluations once every Year.

G. **Diagnostic Office Visits**. We will provide coverage for office visits to diagnose and treat illness or injury.

11. **Diagnostic Imaging Examinations and Diagnostic Radioactive Isotope Procedures**. We will provide coverage for the professional component of the following procedures, when rendered and billed by a Professional Provider: x-ray examinations; radioactive isotope; ultrasound; computerized axial tomography ("CAT") scan; positron emission tomography ("PET") scan; and magnetic resonance imaging ("MRI").

12. **Radiation Therapy**. We will provide coverage for radiation therapy.

13. **Chemotherapy**. We will provide coverage for chemotherapy.

14. **Dialysis**. We will provide coverage for dialysis treatments of an acute or chronic kidney ailment.

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

16. **Mental Health Care**. We will provide benefits for diagnosis and treatment of Mental Illnesses. The coverage described above includes benefits for Biologically-Based Mental Illness and for Children with Serious Emotional Disturbances.

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

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

    B. Determined by us to Medically Necessary.

18. **Podiatry Care**. We will provide coverage for visits to a podiatrist. Benefits will not be provided for services in connection with nail clipping, corns, calluses, flat feet, fallen arches, weak feet, foot strain, or chronic problems of the feet.

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

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

    B. The consultations take place in a physician's office or while you are a registered bed patient in a Facility;

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

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

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

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

20. **Injectable Drug Copayments**. When drugs are administered by injection during the course of a visit to a Professional Provider covered under this section, you are responsible for a Copayment for the drug(s). The drug Copayment is in addition to the Copayment, if any, that applies to the visit to the Professional Provider. The drug Copayment will not apply to vaccinations, allergy injections and injections for treatment of diabetes.

21. **Vision Therapy**. Vision therapy (also known as visual therapy, visual training, vision training, and eye training) involves a range of treatment modalities that include the use of lenses, prisms, filters, optometric phototherapy (Syntonics), occlusion therapy (eye patching), behavioral modalities, and eye exercises (orthoptics, pleoptics). The

therapeutic goal of vision therapy is to correct or improve specific visual dysfunctions. Vision therapy is performed in an optometrist's or ophthalmologist's office 1-2 times weekly for a number of months, with additional home exercises done as reinforcement. We will provide coverage for Medically Necessary vision therapy services performed by a Professional Provider that are not experimental or investigational as defined in Section 14.

22. Applied Behavior Analysis ("ABA") for the Treatment of Autism Spectrum Disorders ("ASD"). We will provide medically necessary coverage for the screening, diagnosis and treatment of ASDs. This will include medically necessary ABA as a behavioral intervention for serious behavior impairments associated with ASD and not as an early intervention program for developmental delays. We will not cover such benefits to the extent provided by a school district under an individualized educational program, an individualized family service plan, or an individualized services plan. When applicable, a program or plan should be completed through the school district before a request for coverage is submitted to the Fund.

In order for ABA services to be eligible for coverage, the ABA services must be rendered by Licensed Behavior Analysts (LBA) or Certified Behavior Analyst Assistants (CBAA) under supervision by an LBA. Coverage may also be provided for individuals who perform tasks that require no professional skill or judgment that are necessary to the provision of ABA under the supervision and direction of an LBA or other authorized supervisor so long as such tasks are consistent with Article 167 of the NYS Education Law and any regulations thereunder.

You will be required to submit to the Fund the following information for it to determine whether ASD benefits are medically necessary (as applicable):

A. The documented assessment report including the ASD diagnosis, with the DSM-5 criteria;

B. Any documented reports completed for psychological and/or other completed testing;

C. Copies of the member's individualized education program plan;

D. Progress notes and discharge plan of the early intervention plan or pre-school special education program;

E. The following documentation in connection with making a medical necessity determination for ABA:

(1) A copy of the assessment or treatment plan to identify the target behaviors for ABA;

(2) Frequency, duration and location of the requested ABA sessions;

(3) Certification and credentials of the professional providing ABA; and

(4) The requested clinical supervision hours and documentation to support the request.

ABA programs must also have a documented treatment plan with clear written descriptions of the treatment goals and objectives, as well as the discharge criteria. Treatment plan and progress notes documenting progress of treatment goals may be requested at any point during treatment for review for continuity of care and/or periodic concurrent medical necessity review. Requests for continuation of therapy must be accompanied by documentation maintained by the provider that outlines actual services received and a graphic representation documenting the progress made by the member, which includes all of the following:

F. There is reasonable expectation that the member will benefit from the continuation of ABA therapy as evidenced by mastery of skills defined in the initial plan or a change of treatment approach from the initial plan;

G. The treatment plan is updated on a monthly basis;

H. The treatment plan is submitted for review every 12 months or as state-mandated;

I. Measurable progress is documented and submitted every 12 months with the treatment plan. Continued progress is determined based on improvement in goals as outlined in the provider treatment plan and will focus on improvements in verbal skills, social functioning, and IQ (for children under 4 years);

J. Treatment is not making the symptoms worse; and

K. There is a reasonable expectation based on the member's clinical history that withdrawal of treatment will result in decompensation or loss of progress made or recurrence of signs and symptoms.

SECTION 11

ADDITIONAL BENEFITS

1. **Treatment of Diabetes**. We will provide coverage for the following equipment and supplies for the treatment of diabetes that we determine to be Medically Necessary and when prescribed or recommended by your Professional Provider or other In-Network medical personnel legally authorized to prescribe ("Authorized Medical Personnel"):

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

B. Blood glucose monitors;

C. Blood glucose monitors for the visually impaired;

D. Data management systems;

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

F. Injection aids;

G. Cartridges for the visually impaired;

H. Insulin pumps and appurtenance thereto;

I. Insulin infusion devices; and

J. Additional Medically Necessary equipment and supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

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

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

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

2. Durable Medical Equipment; External Prosthetic Devices; Orthotic Devices; Medical Supplies; Hearing Aids.

A. **Durable Medical Equipment**. We will provide coverage for the rental, purchase, repair or maintenance of durable medical equipment and for supplies and accessories necessary for the proper functioning of the equipment. We will provide coverage for durable medical equipment that your physician or other licensed/authorized provider and the Plan Administrator determine to be Medically Necessary. The equipment must be the kind that is generally used for a medical purpose, as opposed to a comfort or convenience purpose. We will determine whether the item should be purchased or rented. Durable medical equipment is equipment that can withstand repeated use; can normally be rented and reused by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a person's home. Examples of covered

equipment include, but are not limited to: crutches, wheelchairs (we will not pay for motor-driven wheelchairs unless Medically Necessary), a special hospital type bed, or a home dialysis unit. Examples of equipment we will not cover include, but are not limited to: air conditioners, humidifiers, dehumidifiers, air purifiers, sauna baths, exercise equipment or medical supplies. No coverage is provided for the cost of rental, purchase, repair or maintenance of durable medical equipment covered under warranty or the cost of rental, purchase, repair or maintenance due to misuse, loss, natural disaster or theft, unless approved in advance. No coverage is provided for the additional cost of deluxe equipment that is not Medically Necessary. We will not provide coverage for delivery or service charges, or for routine maintenance.

B. **External Prosthetic Devices**. We will provide coverage for external prosthetic devices necessary to relieve or correct a condition caused by an injury or illness. We will cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Your physician must order the prosthetic device for your condition before its purchase. Although we require that a physician prescribe the device, this does not mean that we will automatically determine you need it. The Plan Administrator will determine if the prosthetic device is Medically Necessary. We will only provide benefits for a prosthetic device that we determine can adequately meet the needs of your condition at the least cost. A prosthetic device is an artificial organ or body part, including, but not limited to, artificial limbs and eyes. External prosthetic devices include, for example, the following that are used to replace functioning natural body parts: artificial arms, legs, and eyes; ostomy bags and supplies required for their use; and catheters. Prosthetic devices do not include, for example: hearing aids; eyeglasses; contact lenses; medical supplies; or foot orthotics such as arch supports or insoles, regardless of the Medical Necessity of those items. Dentures or other devices used in connection with the teeth are also not covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Benefits will be provided for wigs when hair loss is due to a medical condition, such as following chemotherapy or radiation therapy for the treatment of cancer.

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

C. **Orthotic Devices**. We will provide coverage for orthotic devices that are rigid or semi-rigid (having molded plastic or metal stays) when the devices are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion

of an impaired body part; or relieve or correct a condition caused by an injury or illness. We will cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Orthotic devices include orthopedic braces and custom-built supports. Your physician must order the orthotic device for your condition before its purchase. Although we require that a physician prescribe the device, this does not mean that we will automatically determine you need it. The Plan Administrator will determine if the orthotic device is Medically Necessary. We will only provide benefits for an orthotic device that we determine can adequately meet the needs of your condition at the least cost.

D. **Medical Supplies**. We will provide coverage for disposable medical supplies when you are not an inpatient in a Facility and we determine that a large quantity is necessary for the treatment of conditions such as cancer, diabetic ulcers, surgical wounds and burns. Disposable medical supplies: are used to treat conditions caused by injury or illness; do not withstand repeated use (cannot be used by more than one patient); and are discarded when their usefulness is exhausted. Examples of disposable medical supplies include: bandages; surgical gloves; tracheotomy supplies; and compression stockings. Your physician must order these supplies. Not included in this benefit are: supplies that we consider to be purchased primarily for comfort or convenience; delivery and/or handling charges.

E. **Hearing Aids**. We will provide coverage for hearing aids as prescribed by a physician as set forth in the Schedule of Benefits. Over-the-counter hearing aids are not covered by the Plan. Participants and their eligible dependents enrolled in the Plan may also utilize the TruHearing benefit offered by Excellus BlueCross BlueShield. TruHearing offers a wide selection of the latest digital hearing aids at prices 30-60% below average.

When you purchase hearing aids through TruHearing, you also get:

- A 45-day risk-free trial;
- 3 follow-up visits with a TruHearing audiologist or hearing instrument specialist for fitting and adjustments free of charge;
- 3-year manufacturer's warranty for repairs and one-time loss and damage replacement; and
- 48 free batteries per aid.

To get started, all you have to do is call TruHearing at 1-844-277-2557 Monday through Friday 8 a.m. to 8 p.m. TTY/TDD users should call 1-800-975-2674.

A Hearing Consultant will answer all your questions and schedule you for a hearing exam at a TruHearing provider in your area.

Visit TruHearing.com for more information.

3. **Pre-hospital Emergency Services and Transportation**. We will provide coverage for services to evaluate and treat an Emergency Condition when such services are provided by an ambulance service. We will also provide coverage for land ambulance transportation to a Hospital by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

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

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

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

D. Serious disfigurement of such person.

4. **Ambulance Service**. In addition to the services described in Paragraph 3 above, we will also provide coverage for the following Medically Necessary services provided by a certified ambulance service:

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

B. Air ambulance service for an Emergency Condition.

C. Transportation between Facilities.

Air ambulance services will be covered at 100% of the regional Medicare rate as published by the Centers for Medicare & Medicaid Services.

5. **Care in a Freestanding Urgent Care Center**. We will provide coverage for care at a freestanding urgent care center to treat your illness or condition. We will provide coverage for medical visits of Professional Providers who are not employees or interns of the urgent care center.

6. **Individual Case Management.**

A. **Alternative Benefits**. If you agree to participate and abide by the policies, in addition to benefits specified in this Plan, we may provide, outside the terms of this Plan, benefits for services, for up to a 60-day period, furnished by any In-

Network Provider pursuant to the alternative treatment plan of ours for a Member whose condition would otherwise require hospitalization. We may provide such alternative benefits if and only for so long as we determine, among other things, that the alternative services are Medically Necessary, cost-effective and feasible, and that the total benefits paid for such services do not exceed the total benefits to which you would otherwise be entitled under this Plan in the absence of alternative benefits. If we elect to provide alternative benefits for a Member in one instance, it shall not obligate us to provide the same or similar benefits for any Member in any other instance where the alternative treatment is not Medically Necessary, cost-effective and feasible, nor shall it be construed as a waiver of our right to administer this Plan thereafter in strict accordance with its expressed terms. At the expiration of such 60-day period, you may apply in writing for a continuation of the alternative benefits and services being provided outside the terms of this Plan. Upon such application for renewal, we will review the patient's condition and may agree to a renewal of such alternative benefits and services. Renewals must be in writing and our determination will be final. The alternative benefits you receive will be in lieu of the benefits we would normally provide to you under this Plan ("the contractual benefits") for the treatment of your condition. As a result, we may require you to agree to waive certain contractual benefits in order to receive the alternative benefits agreed upon. You may return to utilization of contractual benefits at any time upon prior written notice to us. However, the contractual benefits remaining available to you will be reduced in a manner that appropriately reflects the alternative benefits you used.

SECTION 12

EMERGENCY CARE

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

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

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

SECTION 13

HUMAN ORGAN AND BONE MARROW TRANSPLANTS

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

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

2. **No Coverage of Experimental or Investigational Organ Transplants**. We will not provide coverage for any benefits for an organ transplant we determine to be experimental or investigational. We maintain and revise from time to time a list of organ transplant procedures which we determine not to be experimental or investigational and that, therefore are covered under this Plan. You may contact us if you have a question concerning whether a particular transplant procedure is covered.

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

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

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

SECTION 14

EXCLUSIONS

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

1. **Acupuncture.** We will not provide coverage for acupuncture.

2. **Act of War.** We will not provide coverage for any service or care related to an illness or injury that occurs as a result of any war or act of war, whether declared or undeclared.

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

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

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

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

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

   B. Our procedures have been followed to authorize the service or care; and

   C. The Plan Administrator determines, in advance, that the service or care is Medically Necessary and covered under the terms of this Plan.

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

7. **Criminal Behavior**. We will not provide coverage for any service or care related to the treatment of an illness, accident or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred.

8. **Custodial Care**. We will not provide coverage for any service or care that is custodial in nature, or any therapy that we determine is not expected to improve your condition. Care is considered custodial when it is primarily for the purpose of meeting personal needs and

includes activities of daily living such as help in transferring, bathing, dressing, eating, toileting, and such other related activities.

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

10. **Developmental Delay**. We will not provide coverage for educational services related to evaluation, testing and treatment of behavioral disorders, learning disabilities, minimal brain dysfunction, development and learning disorders, or developmental delays. We will also not provide benefits for any covered service or care set forth in this Plan when rendered in connection with such conditions, unless Medically Necessary.

11. **Disposable Supplies; Hair Prosthetics; Household Fixtures**. We will not provide coverage for any service or care related to:

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

B. Hair prosthetics, or hair implants (benefits will be provided for wigs when hair loss is due to a medical condition, such as following chemotherapy or radiation therapy for the treatment of cancer); and

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

12. **Reversal of Elective Sterilization**. We will not provide coverage for any service or care related to the reversal of elective sterilization.

13. **Employer Services**. We will not provide coverage for any service or care furnished by a medical department or clinic provided by your employer.

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

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

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

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

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

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

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

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

positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

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

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

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

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

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

16. **Gene Therapy:** We will not provide coverage for the gene therapy, including but not limited to, all gene therapy drugs (for example, Zolgensma, Luxterna, and Strensiq). The Fund does not cover any charges related to gene therapy, regardless of whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered experimental or investigational.

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

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

Medicare, we will reduce our benefits by the amount Medicare would have paid for the services. However, this exclusion will not apply to you if one of the following applies:

A. **Eligibility for Medicare by Reason of Age**. You are entitled to benefits under Medicare by reason of your age and you are in "current employment status" (working actively and not retired) with an employer participating in the Plan.

B. **Eligibility for Medicare by Reason of Disability Other than End-Stage Renal Disease**. You are entitled to benefits under Medicare by reason of disability (other than end-stage renal disease) and you are in "current employment status" (working actively and not retired) with an employer participating in this Plan.

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

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

20. **Infertility Treatment Services**. We will not provide coverage for the diagnosis and treatment of infertility.

21. **Maternity Care Coverage for Dependent Children**. We will not cover professional services relating to maternity care for your dependent child. The Fund will provide coverage for inpatient care services for your dependent child as described in Section 6, "Inpatient Care".

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

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

24. **Non-Covered Service**. We will not provide coverage for any service or care that is not specifically described in this Plan as a covered service; or that is related to service or care

not covered under this Plan; even when an In-Network Provider considers the service or care to be Medically Necessary and appropriate.

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

26. **Personal Comfort Services**. We will not provide coverage for the following service or care that is for personal comfort: radio, telephone, television, or beauty and barber services.

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

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

29. **Prohibited Referral**. We will not provide coverage for any pharmacy, clinical laboratory, radiation therapy, physical therapy, x-ray, or imaging services that were provided pursuant to a referral prohibited by law.

30. **Reproductive Procedures**. We will not provide coverage for the following reproductive procedures or services: in vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cloning, sperm banking and donor fees associated with artificial insemination or other procedures, or other procedures or categories of procedures excluded by statute.

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

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

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

34. **Services Starting Before Coverage Begins**. If you are receiving care on the Effective Date of your coverage under this Plan, we will not provide benefits for any service or care you receive:

A. Prior to the Effective Date of your coverage under this Plan; or

B. On or after the Effective Date of your coverage under this Plan, if that service or care is covered under any other health benefits contract, program, or plan.

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

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

37. **Transsexual Surgery and Related Services**. We will not provide coverage for surgery, or for any other service or care set forth in this Plan that is related to or leads up to surgery that is designed to alter the physical characteristics of your biologically determined gender to those of another gender, unless Medically Necessary.

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

39. **Vision and Hearing Therapies and Supplies**. We will not provide coverage for any service or care related to:

A. Eyeglasses, lenses, frames, or contact lenses except for the initial prescription for contact lenses or lenses and frames after cataract surgery; and

B. Vision or hearing therapy, over-the-counter hearing aids, vision training, or orthotics. We will provide coverage for hearing aids prescribed by a physician.

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

41. **Workers' Compensation.** We will not provide coverage for any service or care for which benefits are provided under a workers' compensation or similar law. We will not provide coverage for the services even if you do not receive benefits because: a proper or

timely claim for the benefits is available to you was not submitted, or you fail to appear at a workers' compensation hearing.

Notwithstanding the foregoing, where required by the No Surprises Act, none of the exclusions in this section will apply to Emergency Services for an Emergency Condition.

SECTION 15

SUBMISSION OF CLAIMS

How to Submit a Claim for Medical Benefits

If Medicare or another health plan is the primary plan, claims should first be submitted to those plans and then to Excellus BlueCross BlueShield with copies of their explanation of benefits or denial.

Claims for services or supplies needed for an illness or injury resulting from an occupational cause, no-fault auto accident, or incident for which benefits could be payable by a third party should be submitted to the appropriate entity. This type of claim is not payable under the Plan. Be sure to advise the provider of these situations to avoid misallocation of benefits.

In-Network Provider Claims

An In-Network Provider will bill Excellus BlueCross BlueShield directly for benefits. If you are eligible for benefits, you or your dependent need only present your identification card and complete any information requested by the provider. Be sure to give the In-Network Provider full information on other health plans and history of any accidental injuries.

Non-Participating Provider Claims

If you go to an Out-of-Network Provider, ask the provider to submit the claim to their local BlueCross BlueShield Plan. If they will not file the claim, refer to the instructions on the Excellus BlueCross BlueShield claim form for the specific items of information required. A claim form may be obtained from www.excellusbcbs.com or by calling Excellus BlueCross BlueShield at the number on your I.D. card. It is your responsibility to submit a properly completed claim form. Payment for services rendered by an Out-of-Network Provider that are subject to the surprise billing protections as described in the 'Protection from Surprise Bills' section of the Plan will be made directly to the Out-of-Network Provider.

Other Health Claim Submissions

If you are billed for covered services, you must take the following steps to submit a claim for out-of-network benefits:

1. Obtain a claim form from your Fund Office or from Excellus BlueCross BlueShield at their website (www.excellusbcbs.com).

2. Be sure to read the instructions printed on the claim form. **Remember:** You must attach a completed claim form each time you send in medical bills and a separate claim form is needed for each family member.

3. Once you have completed your portion of the claim form, the health care provider can complete his or her portion, if needed, or you may attach itemized bills. If an itemized bill is attached, it must clearly state the patient's name, diagnosis, full description of the service rendered, and an itemized list of charges with dates of service.

4. If services are due to accidental injury, you must provide complete details on how, where, and when such injury was sustained.

5. For services rendered by other than a doctor, the bill should include the provider's signature and tax identification number. Any bill from a nurse must show the date, place and hours of duty, charge per hour, total charge per day and signature, credentials, and registration number.

6. Attach Medicare or other plan explanation of benefits or denial, if appropriate.

All completed forms and itemized bills should be submitted to the address on the claim form.

If you fail to provide necessary information, your claim could be returned to you or missing details could be requested which will delay the determination of benefits. Excellus will advise you of approval or rejection of your claim by mailing an Explanation of Benefits.

The Plan’s procedures concerning initial determinations, adverse benefit determinations and appeals are set forth in Section 7 of the General Eligibility & ERISA Rights Information booklet provided by the Fund.