Member Handbook, Member Contract and Other Legal Information

Excellus

A nonprofit independent licensee of the BlueCross BlueShield Association

#71110999-R 03/06

(EXCHP)

NOTICE OF NON-DISCRIMINATION

Excellus BlueCross BlueShield complies with Federal civil rights laws. Excellus BlueCross BlueShield does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Excellus BlueCross BlueShield provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **Excellus BlueCross BlueShield** at 1-800-650-4359. For TTY/TDD services, call 1-800-662-1220.

If you believe that Excellus BlueCross BlueShield has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Excellus BlueCross BlueShield by:

Mail:	Advocacy Department, P.O. Box 4717, Syracuse, NY 13221
Phone:	1-800-614-6575 for TTY/TDD services, call 1-800-662-1220
Fax:	1-315-671-6656
In person:	165 Court Street, Rochester, NY 14647, OR 333 Butternut Drive, Syracuse, NY 13214

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html
Phone:	1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-650-4359, TTY/TDD 1-800-662-1220.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-650-4359, TTY/TDD 1-800-662-1220.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-650-4359, TTY/TDD 1-800-662-1220.	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-650-4359 (رقم هاتف الصم والبك TTY/TDD 1-800-662-1220.	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니 1-800-650-4359, TTY/TDD 1-800-662-1220.번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-650-4359 (телетайп: TTY/TDD 1-800-662-1220).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-650-4359, TTY/TDD 1-800-662-1220.	Italian
ATTENTION : Si vous parlez français, des serv\ices d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-650-4359, TTY/TDD 1-800-662-1220.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-650-4359, TTY/TDD 1-800-662-1220.	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-650-4359, TTY/TDD 1-800-662-1220.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-650-4359, TTY/TDD 1-800-662-1220.	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-650-4359, TTY/TDD 1-800-662-1220.	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে৷ ফোন করুন ১ 1-800-650-4359, TTY/TDD 1-800-662-1220.	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-650-4359, TTY/TDD 1-800-662-1220.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-650-4359, TTY/TDD 1-800-662-1220.	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کری 1-800-650-4359, TTY/TDD 1-800-662-1220.	Urdu

Notes

Excellus
165 Court Street
Rochester, NY 14647

A nonprofit independent licensee of the BlueCross BlueShield Association

Child Health Plus
HEALTH PLAN FOR KIDS

Dear Parent/Guardian:

Enclosed is your Child Health Plus Subscriber Agreement. Your subscriber agreement will help you understand the many benefits available to your child/children as an Excellus BlueCross BlueShield member. It also provides detailed information about how their coverage works.

We value you as a customer and look forward to providing you with your health care coverage. If you have any questions, please contact our Member Services Department at 1-800-650-4359 or TTY/TDD 1-800-662-1220.

Sincerely,

Aaron Bertram
Vice President, Safety Net and Government Programs

Table of Contents

A Special Message To Child Health Plus Members

Welcome! This is your Child Health Plus member handbook, which is designed to help guide you through your health care coverage. Please read it carefully. You will find a great deal of information on many topics, including the role of your primary care physician and your rights and responsibilities. Your Child Health Plus contract explains in detail which services are and are not covered.

If your income has changed and you think that your premium could be affected, you may ask for a review. Call the phone number listed on the back of your ID card and request an Income Review Form to be sent to you. Please continue to pay your current premium until you receive notification of the results of the review.

If you need additional information, have questions, or have any concerns or complaints about any aspect of coverage, you should contact us. Please see the section in the back of this handbook entitled "How to Contact Us" for telephone numbers, office hours and our website address.

Arrangements can be made for our non-English-speaking and hearing-impaired members. We have many representatives who speak languages in addition to English. We also have interpretive services available, if needed. TTY equipment is available for our hearing impaired members.

Your Identification Cards

Once enrolled, you will receive an identification card for medical services. Additional identification cards can be obtained by calling us.

Always carry your identification card with you to present whenever and wherever you receive care. Please check your card for accuracy and notify us of any errors immediately.

Child Health Plus In General

As a member of Child Health Plus, you must receive all your care from a panel of participating physicians, consultants and facilities. This panel is sometimes referred to as participating providers or as a participating network. To receive your benefits, all services need to be provided within the participating panel and rendered by or referred by your primary care physician ("PCP"). Except for emergencies, certain Ob/Gyn services and certain other services, when your PCP determines you require the services of a specialist, he or she will contact us to request approval. Normally, we respond quickly to your PCP's request for a referral to a specialist in our network.

Referrals for services outside the network may require additional review and approval by our Medical Director. Generally, we approve referrals to non-network specialists only when no participating specialist is qualified to provide the service. Once the referral is reviewed, we will notify both your PCP and the specialist provider of the outcome. If the referral is not approved, you will also receive a notice of denial. Remember, if you seek services outside of the network without a referral from your PCP and without prior approval from us, you will be responsible for the cost of the referral and any associated services.

"Services" refers to all laboratory, radiology and other services related to the care received from the non-participating provider.

Each year, you must recertify for Child Health Plus so that we can determine if you are still eligible for the Program. We will send you a recertification package each year in advance of your recertification date (your anniversary date of enrollment). You must complete the application and provide all necessary documentation in order to remain enrolled in Child Health Plus.

You and Your Primary Care Physician

As a member of Child Health Plus, you choose your PCP from our list of participating internal medicine, family and general practice, and pediatric physicians. To determine if a physician is a participating provider and accepting new patients, you can refer to our Provider Directory or contact us.

Your PCP is your partner in managing and coordinating your health care services. He or she is responsible for coordinating all your medical care, including diagnosis, treatment, referrals to specialists, hospitalization and follow-up care. He or she works with a team of health care professionals, including physician assistants and nurse practitioners, to provide your treatment. Your PCP may periodically also consult with our Medical Director regarding your health care services.

It is important to establish a relationship with your PCP as soon as possible. You may want to arrange a short introductory visit. Remember, your PCP must provide or arrange for all your health care services, except for emergency care. Also, a female member may see a participating OB/GYN two (2) times per year without a referral from her PCP for routine obstetrical and gynecological care, any follow-up care as a result of these examinations, any care required as a result of an acute gynecologic condition, and any outpatient care related to a pregnancy.

Health and Wellness

We want to help you maintain good health. We recommend preventive care and early detection to keep you and your family healthy. We encourage you and your dependents to schedule periodic check-ups and immunizations with your PCP. We also encourage female members to schedule periodic appointments with a provider of obstetrical and gynecological services, including mammograms and pap smears.

Your Relationship With Your Primary Care Physician (PCP)

As a member of Child Health Plus, you must receive all your care from participating providers. A participating provider is a physician, health consultant or facility that enters into an agreement to offer care to our members. Participating providers are credentialed by us and agree to abide by our policies and procedures. Participating providers are listed in our Provider Directory. Our Provider Directory is updated annually. We are continually adding providers to our networks, so if you do not see your provider listed, please contact us. To obtain an additional copy of our Provider Directory, please call us.

Remember, in most instances, your PCP must authorize your care even to a participating provider. In addition, except in an emergency, coverage is not available from a non-participating provider unless the services are referred by your PCP and approved in advance by us.

If you seek services from a non-participating provider without prior approval from us, you will be responsible for the cost of the care by the non-participating provider, as well as any associated services.

Periodically, a participating provider may stop participating with us due, for example, to retirement, closing a practice or relocating. When this happens, we will tell you within 15 days from when we know about the change. If you wish, you may be able to see that provider if you are more than three months pregnant, or, if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days from the time your provider leaves our network.

Your doctor must agree to work with the plan during this time. If any of these conditions apply to you, check with your PCP or call Member Services at the number listed on your ID card.

Changing Your PCP

You may change your PCP by calling us. We will tell you when the change is effective. Until the change becomes effective, the PCP you currently have must render or arrange for any medical care you may need.

If you seek care from another physician before your change becomes effective, you will be responsible for the cost of those services.

Remember, when selecting a new PCP, always call the PCP first to be sure that he or she is a participating physician and can accept you as a new patient.

Changing Your Specialist Physician

Usually, when you need services from a specialist provider, your PCP will refer you to the participating providers that he or she normally refers to in his or her practice.

If you want a different specialist provider or you want to change a specialist provider, you must discuss this request with your PCP. He or she will make the appropriate changes to your referral for the new specialist provider. You do not need to call us directly for permission to change participating specialists.

Accessing Care

Prescription Drug Programs

Your contract includes coverage for prescription drugs. Our prescription drug plans offer coverage under a closed formulary system. This means that our prescription drug coverage is limited to a list of specific drugs. We encourage our doctors to prescribe appropriate prescription drugs reviewed and supported by our Pharmacy and Therapeutic Committee, a committee consisting of community doctors and clinical pharmacists that regularly meets to review prescription drugs, determine guidelines and define coverage categories.

Transitional Care Makes Change Easier

Existing Members: If your current provider no longer participates in our network, for reasons other than quality of care, you may continue treatment with this provider for up to 90 days from the date you receive notice from us that he or she is no longer participating in our network.

New Members: If you're a new member of Child Health Plus with a life-threatening disease or condition, or a degenerative, or disabling condition or disease, and the provider you are currently seeing does not participate in our provider network, you may request to continue an ongoing course of treatment with this provider for 60 days from your enrollment in Child Health Plus.

Pregnant Women: Pregnant women in their 2nd or 3rd trimester of pregnancy may continue with their provider (in either the case of a provider termination or a new member enrollment) through a transitional period during which the member may receive any post-partum care directly related to the pregnancy.

In any situation above, in order to continue with the nonparticipating provider, the provider must accept our reimbursement as payment in full, adhere to our quality assurance program, agree to provide us with necessary medical information related to care, and follow our policies and procedures. To request transitional care, ask your PCP to contact us or you can call us directly.

Accessing Medical Care

Whenever you feel you need medical care, you should contact your PCP. He or she knows your medical history and is the best person to advise you. Your PCP or his or her on-call physician is available to you 24-hours a day. Routine appointments with your providers should be scheduled as far in advance as possible. Inform your providers that you are a member of Child Health Plus and show your identification card at every visit. (To access care in an emergency, see the "Accessing Emergency Care" section.)

If your PCP determines that you need to see a specialist, he or she will generate a referral for you to a participating provider. Remember, in order for specialist or hospital visits to be covered, the visit must be referred by your PCP.

Out-of-Network Referrals

If your PCP refers you to a provider not participating in our network, that request must be approved in advance by our Medical Director. To request an out-of-network referral, have your PCP contact us or you can call us directly. After reviewing the request, we will determine if there is an appropriate provider in our participating panel to treat your condition.

If we determine that our participating panel of providers does not include a provider with appropriate training and experience to treat your condition, we will approve a referral to a non-participating provider.

Once you have been approved for a referral to a specialist outside of our plan, the services will be covered in full. This means you will not have to pay anything to the specialist for your care.

Standing Referrals

If we determine that you require ongoing care from a specialist for treatment of your condition, we will approve a request for a standing referral to a specialist. A standing referral allows you to see a specialist for a specified number of visits over a specified period of time without first having to obtain a referral from your PCP.

To request a standing referral, have your PCP contact us or you can call us directly. We will not provide a standing referral to a non-participating provider unless we determine we do not have an appropriate provider in our network.

Specialist Care Coordinator

If we determine that you have a life-threatening condition or disease or a degenerative and disabling condition or disease requiring specialized medical care over a prolonged period of time, we will approve a request for a specialist care coordinator to act as a PCP, upon our approval of a treatment plan. The following conditions could potentially require a specialist care coordinator: HIV/AIDS, cerebral palsy, cystic fibrosis, cancer, hemophilia, multiple sclerosis, sickle-cell disease, and conditions necessitating an organ transplant.

A specialist care coordinator is a specialist with expertise in treating your condition who can provide and/or coordinate your care. To request a referral to a specialist care coordinator, have your PCP contact us or you can call us directly. We will not provide a referral to a specialist care coordinator who does not participate with our panel unless we determine we do not have an appropriate provider in our network.

Specialty Care Centers

If we determine that you have a life-threatening condition or disease or a degenerative and disabling condition or disease requiring specialized medical care over a prolonged period of time, we will approve a request for a specialty care center, upon our approval of a treatment plan.

The following conditions could potentially require a specialty care center: HIV/AIDS, cerebral palsy, cystic fibrosis, cancer, hemophilia, multiple sclerosis, sickle-cell disease, and conditions necessitating an organ transplant. A specialty care center is a center accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the condition for which it is accredited or designated.

To request a referral to a specialty care center, have your physician contact us or you can call us directly. We will not provide a referral to a specialty care center that does not participate with our panel unless we determine we do not have an appropriate center in our network.

Accessing Emergency Care

If you have an emergency medical condition as defined below, immediately go to the emergency room of the nearest hospital. Services for an emergency medical condition do not require prior authorization. An emergency medical condition is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in 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 the person or others in serious jeopardy; or serious impairment to such person's bodily functions; or serious dysfunction of any bodily organ or part of such person; or serious disfigurement of such person.

Some examples of conditions considered emergency medical conditions are severe chest pain, poisoning, or unconsciousness.

You must call your PCP within 24 hours, or as soon as reasonably possible after the emergency room visit to arrange for follow-up visits and continuing care. In addition, if you are admitted from the emergency room to the hospital as a registered bed patient, you or someone acting on your behalf must notify your Primary Care Physician within two business days (or as soon as reasonably possible, if later) after the admission.

This is true whether you are away from home, away at school or overseas. If you are overseas, you may need to pay for care at the time of service. To obtain reimbursement from us, see our section entitled "How to Submit a Claim".

You must have a referral from your PCP prior to seeking care in an emergency room if the condition does not appear to be an emergency medical condition as defined above.

How Providers are Reimbursed

We pay participating professional providers (e.g., physicians and other licensed health care professionals) based on our fee schedule developed for each procedure or service.

We pay participating hospitals based on the rate we have negotiated for inpatient and outpatient services.

We pay participating institutional/facility based providers (e.g., ambulance, home health agencies, free standing ambulatory surgery centers, hospices) based on a negotiated rate or our fee schedule developed for each procedure or service.

In some cases, we reimburse providers on a capitation basis. Capitation means that we pay providers a fixed dollar amount in advance on a per member per month basis.

Under a capitation payment method, providers receive this fixed amount regardless of the number of services they provide to a member. We use capitation for certain doctor groups and physician organizations such as independent practice associations (IPAs).

Medically Necessary Care

Your coverage will only cover services that are medically necessary and appropriate for the diagnosis and treatment of your illness or injury. By medically necessary and appropriate we mean:

Your tests, treatment, services, and supplies must be consistent with the diagnosis and treatment of your illness or injury; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative.

We will decide whether care is/was medically necessary. We will base our decision in part on review of your medical records.

We will also evaluate medical opinions we receive. This could include the medical opinion of a professional society, peer review committee or other groups of physicians. Care will be provided at the most appropriate level for inpatient, outpatient, or out-of-hospital services and is not solely for the convenience of your health care provider, hospital, or for you. The fact that a health care provider prescribes, orders, recommends or approves a medical treatment, or length of time care is received, does not by itself make the services medically necessary.

Experimental Or Investigational Procedures

We will only cover a treatment, procedure, drug, device or any related hospitalization if it is NOT determined to be experimental or investigational. We have a medical policy department made up of a group of physicians and nurses which determines medical policy and coverage on new technology in coordination with contract definitions of medical necessity, medical appropriateness, and experimental/ investigational procedures.

A variety of sources, such as the Food and Drug Administration (FDA), clinical practice guidelines, and professional journals and articles, are utilized in researching new technologies for inclusions as a covered benefit. Any inclusions of technologies in our benefit package are reviewed and approved by our medical policy department.

Grievances

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

Filing a Grievance:

Our Grievance Procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by us. To initiate a grievance, just contact us. We keep all requests and discussions confidential and we'll take no discriminatory action because of your issue.

We have a process for both standard and expedited grievances, depending on the nature of your inquiry. We maintain a file on each grievance.

Filing a First-Level Grievance

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

When we receive your first-level grievance, we'll mail an acknowledgment letter within 15 calendar days.

This acknowledgment letter will include the name, address, and telephone number of the person handling your grievance, and indicate what additional information, if any, must be provided.

If your first-level grievance relates to a pre-service claim (a request for a service or treatment that has not yet been received), we'll decide the first-level grievance and notify you of our determination in writing within 15 calendar days of receipt of your first-level grievance request.

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

If your first-level grievance relates to a post-service claim (a claim for a service or treatment that has already been provided), or relates to a matter unrelated to a claim or a request for service we'll decide the first-level grievance and notify you of our determination in writing within 30 calendar days of receipt of your first-level grievance request.

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

Filing a Second-Level Grievance

If you're not satisfied with the resolution of the first-level grievance, you or your designee may file a second-level grievance by phone, in person, or in writing. You have up to 180 calendar days from receipt of the first-level grievance determination to file a second-level grievance.

One or more qualified personnel at a higher level than the personnel that rendered the first-level grievance determination will review it, or if it's a clinical matter, a clinical peer reviewer will look into it.

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

If your second-level grievance relates to a pre-service claim, we'll decide the second-level grievance and notify you of our determination in writing within 15 calendar days of receipt of your second-level grievance request.

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

If your second-level grievance relates to a post-service claim, or relates to a matter unrelated to a claim or request for a service, we'll decide the second-level grievance and notify you of our determination in writing within 30 calendar days of receipt of your second-level grievance request.

Notice of Determination:

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

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

Call the New York State Department of Health at 1-800-206-8125 or write them at:

New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237
www.health.state.ny.us

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

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

Utilization Review

HMOs, as managed care programs, review proposed and rendered health services to determine whether the services are or were medically necessary or experimental or investigational ("medically necessary"). This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being rendered (pre-service); when the service is being rendered (concurrent); or after the service is rendered (post-service).

We have developed Utilization Review policies to assist us in administering the Utilization Review program. These policies describe the process and procedures of Utilization Review activities. Reviews are conducted by registered nurses and our Medical Directors.

All determinations that services are not medically necessary will be made by licensed physicians. We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not or were not medically necessary. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review at our office. For more information, you can contact us.

Once we have all the information necessary to make a decision, our failure to make a utilization review determination within the applicable time frames set forth below shall be deemed an adverse determination subject to an internal appeal.

See "How to Contact Us".

Pre-Service Reviews

All requests for prior authorization of care are reviewed for medical necessity (including the appropriateness of the proposed level of care and/or provider). The initial review is performed by a nurse. If the nurse determines that the proposed care is medically necessary, the nurse will authorize the care. If the nurse determines that the proposed care is not medically necessary or that further evaluation is needed, the nurse will refer the case to a licensed physician.

Utilization review decisions for services requiring pre-authorization (pre-service reviews) will be made, and notice provided to you (or your authorized designee) and your provider, by telephone and in writing, with three business days of receipt of all information necessary to make a decision.

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

With respect to urgent pre-service claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone, within one calendar day of receipt of the request. Written notice will follow within three calendar days of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone within 48 hours of the receipt of the information. Written notice will follow within 72 hours of our receipt of the information.

Concurrent Reviews

When you are receiving services that are subject to concurrent review, a nurse will periodically assess the medical necessity and appropriateness of care you receive throughout the course of treatment. Once a case is assigned for concurrent review, a nurse will determine whether the services are medically necessary. If so, the nurse will authorize the care. If the nurse determines that medical necessity is lacking or that further evaluation is needed, the nurse will refer the case to a licensed physician.

Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to your provider, by telephone and in writing, within 1 business day of receipt of all information necessary to make a decision.

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

If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date services may begin, and the date of the next scheduled concurrent review of the case.

Post-Service Reviews

At our option, a nurse will review retrospectively the medical necessity of claims that are subject to utilization review.

If the nurse determines that care you received was medically necessary, the nurse will authorize the benefits. If the nurse determines that medical necessity was lacking, the nurse will refer the case to a licensed physician.

Utilization review decisions for services that have already been received (post-service reviews) will be made, and notice provided to you and your provider, in writing, within 30 business days of receipt of all information necessary to make a decision. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. We will make a determination and notify you and your provider within 15 calendar days of the receipt of the information. If we do not receive the additional information within 45 days, we will consider the case closed and no decision will be made. If this happens, you have the right to appeal (see "Internal Appeals of Adverse Determinations" on page 9).

Notice of Adverse Determination

A notice of adverse determination (notice that a service is not medically necessary) will include the reasons, including clinical rationale, for our determination. The notice will also advise you of your right to appeal our determination, give instructions for requesting an internal appeal and for initiating an external appeal and specify that you may request a copy of the clinical review criteria used to make the determination.

The notice will specify additional information, if any, needed for us to review an appeal. We will send notices of determination to you or your designee and to your health care provider.

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

Internal Appeals of Adverse Determinations

You, your designee and, in retrospective review cases, your health care provider, may request an internal appeal of an adverse determination, either by telephone, in person, or in writing. You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal.

We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

If your appeal relates to care you are seeking (pre-service review), we will decide internal appeals within 30 calendar days or receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and your health care provider if he or she requested the review) within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

If your appeal relates to a post-service event, we will decide the appeal within 60 calendar days of the receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and your health care provider if he or she requested the review) within 2 business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

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

For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal.

Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appel request.

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

Notice of Determination of Internal Appeal

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

External Appeal

You may file an application for an external appeal by a state-approved external appeal agent if you have received a denial of coverage based on medical necessity or because the service is experimental and/or investigational.

To be eligible for an external appeal, you must have received a final adverse determination as a result of our internal appeal process or we must have jointly agreed to waive the internal utilization review appeal process.

You may obtain an external appeal application:

- from the New York State Insurance Department at 1-800-400-8882, or its Web site (www.ins.state.ny.us);
- by contacting us at (585) 546-3559 or toll free at 1-800-650-4359.

The application will provide clear instructions for completion. A fee of $50 may be required to request an external appeal. This money will be refunded if the external appeal is decided in your favor. You may obtain a waiver of this fee if you meet our criteria for a hardship exemption.

The application for external appeal must be made within 45 days of your receipt of the notice of final adverse determination as a result of our appeal process, or within 45 days of when we jointly agree to waive the internal appeal process. The application will provide clear instructions for completion.

You will lose your right to an external appeal if you do not file an application for an external appeal within 45 days from your receipt of the final adverse determination from the internal appeal.

The application will instruct you to send it to the New York State Department of Insurance.

You (and your doctors) must release all pertinent medical information concerning your medical condition and request for services.

An independent external appeal agent approved by the state will review your request to determine if the denied service is medically necessary and should be covered by us. All external appeals are conducted by clinical peer reviewers. The agent’s decision is final and binding on both you and us.

An external appeal agent must decide a standard appeal within 30 days of receiving your application for external appeal from the state.

Five (5) additional business days may be added if the agent needs additional information. If the agent determines that the information submitted is materially different from that considered by us, we will have three (3) additional business days to reconsider or affirm our decision.

You will be notified within two (2) business days of the agent's decision.

You may request an expedited appeal if your doctor can attest that a delay in providing the recommended treatment would pose an imminent or serious threat to your health. The external appeal agent will make a decision within three (3) days for expedited appeals. Every reasonable effort will be made to notify you and us of the decision by phone or fax immediately. This will be followed immediately by a written notice.

Case Management

In an effort to make sure your health care needs are met and that you will not be faced with making important medical decisions alone during a serious illness, we offer a case management program. Case Management is a voluntary program that can provide you with personalized care planning by a team of nurses, medical social workers and physicians, all of whom are familiar with the resources available to help you with complex or catastrophic illness, injury or a high risk pregnancy. Our Case Management Services include, for example, Catastrophic, High Risk Obstetrics and Diabetes programs.

A team of nurses and physicians familiar with available medical and community resources will make sure your health care needs are met and that you will not be faced with making important medical decisions alone during a serious illness, injury or difficult pregnancy. This program may also provide alternative care that is not otherwise covered under your contract. If you want further information on this program, please contact us.

Quality Improvement

We are committed to providing quality health care for all our members. Our Quality Improvement Program is designed to monitor and evaluate the quality of care and services provided to you and your family members, and pursues opportunities to enhance these services. We encourage physicians to provide preventive health services, such as diabetic eye exams and childhood and adolescent immunizations.

We confirm that your physician is providing these services for you by a review of your medical records conducted by our nurses. Please be assured that any information provided by your physician or reviewed by our nursing staff is considered strictly confidential.

In addition to monitoring and evaluating the quality of care and service provided to our members, we also monitor the quality of health care provided by our participating providers. This is accomplished through our credentialing program, which ensures that providers meet established standards for licensure, education, professional privileges, access and availability.

Credentialing is the initial and on-going collection, verification and review of evidence that a health care professional is qualified to practice his/her licensed profession. This program facilitates the retention of cost-effective, quality providers who enhance our health care delivery system. If you have a concern about a provider or want to obtain information about pending disciplinary actions, call the Office of Professional Misconduct at 1-800-663-6114.

Quality Commitments To Our Members

Quality care is our priority and that of our providers. Improving patient health is an interactive process between physicians and patients, informed through patient education and open communication. That's why we're committed to:

Promoting Patient Choice

- Treatment options are openly discussed between physicians and you. Treatment decisions are based on the best available scientific information, clinical evidence, and your unique needs.

Recognition of Physician Leadership

- We support the patient-physician relationship by championing consumer protections, fostering open communications, and promoting state-of-the-art quality oversight.
- Qualified and experienced participating physicians assume the leadership role in providing appropriate health care.
- We respect physician advocacy for their patients.
- We view medical ethics as the cornerstone of a successful physician-patient relationship.
- Quality improvement activities and medical policy are developed, monitored, and refined by our medical directors, in cooperation with participating area physicians, and according to sound medical judgment.

Respect for Patients

- Patient satisfaction is a priority. Our managed care plans foster satisfaction by meeting our members' needs for quality, accessibility, affordability, flexibility, responsiveness, participation, and advocacy in health care.
- Patients have the right to information about their health care and health plan. Open discussion of all information relevant to the patient's health is critical to the physician-patient relationship.
- Proactive member education and disclosure of health plan practices allow patients to make educated decisions about their health care options. We inform our members about how to use their benefits and take the guesswork out of obtaining health care.
- We are committed to satisfying our members' most important expectation: quality health care.
- Health care is personal and confidential. Patient information is handled in the strictest confidence.
- We provide all patients and physicians an accessible, fair, and reasonable forum for lodging and resolving grievances and appeals.
- Our plans offer access to a full range of appropriate health care services from preventive care and primary care services to highly specialized treatment and follow-up care.

You Can Help Us Combat Fraud and Abuse

Fraud makes the cost of good care rise for honest people, and that's just wrong. Our company has a strong and ongoing commitment to identifying, documenting, and prosecuting cases of fraud, as well as to educating both our providers and members of the consequences and penalties for committing fraud.

Our first and most important method of discovering fraud and abuse is through information provided by you, our member.

Our employees and providers also assist us in this process. We likewise call upon the expertise and resources of a wide variety of law enforcement and professional fraud detection organizations to support and supplement our activities. In addition, we use technology and computer systems to detect fraud.

If you have information about potential fraud and abuse, call our hotline number listed in our "How to Contact Us" section. It operates 24 hours a day and it's confidential.

Member Enrollment: Changes, Additions, and Deletions

It is important that your contract information and membership records are correct. Please call us before you move outside of our service area, become eligible for Medicare, or obtain other insurance. Also notify us of any address or telephone number changes.

Participation in Policy Development

We welcome your input on policies that we have developed or those you would like us to initiate. If you wish to share any ideas with us, we encourage you to call us or to write to us. We will forward your ideas to the department responsible for developing the type of policy involved, and your suggestions will be reviewed and considered.

You'll then receive a response to your comments. Plus, we review member complaints, member satisfaction information, new technology, and new procedures at determine if changes should be made to your benefits.

Other Important Information

Confidentiality: We have policies and procedures in place to protect your medical records and any information obtained about you.

When you become covered under this plan, you automatically give us permission to obtain and use those records and that information. We hold your medical records to be confidential and, as such, will not release the information to anyone without your written consent. All employees are instructed in medical record confidentiality and are required to sign a confidentiality statement of understanding.

Our participating physicians and other providers are regularly instructed in and observe confidentiality procedures regarding your medical information. Copies of any medical records are securely stored in locked cabinets and reviewed only by designated employees with a need to know the information.

Advance Directives and Informed Consent: You have the right under New York State law to make medical care decisions, accept or refuse medical treatment and make advance directives about your medical care in the event you lack capacity to make such a decision. New York law allows for three types of advance directives: do not resuscitate orders (DNR), health care proxies, and living wills. For information on advance directives, or a copy of a health care proxy, please call us.

Your Financial Responsibilities: As a member of Child Health Plus, you may be required to pay all or a portion of the premium, depending on your income level. Your portion of the premium is due by the first day of each month. Paying your bill does not ensure that you have Child Health Plus coverage. You must follow all program requirements regarding enrollment and recertification.

In addition, if you choose to have treatment or services not covered, you must pay these costs directly to the provider.

If you used services of the emergency room, for other than an emergency medical condition, you will be responsible for the cost of the emergency room visit as well as any associated charges. Check your contract for details.

How to Submit a Claim: Most claims are submitted directly to us by the provider of service. However, when you see a non-participating provider, you may be asked to pay for services when you receive them, or you may receive an itemized bill.

The bill must be on the provider's letterhead and should include the date of service, amount charged, description of services provided, diagnosis, your name, and member ID number. We will normally send payment directly to the provider. If the bill is marked paid, we will reimburse you directly.

If you have received and paid for emergency care when traveling overseas, send us a receipt with English translation, U.S. dollar amount, services rendered, date of services, diagnosis, and proof of payment.

See "How to Contact Us" section for the address to send claims to.

If you need additional information, have questions, or have any concerns, complaints, or problems about any aspect of coverage, please give us a call, we want to hear from you.

Your Member Rights and Responsibilities

As a member of our plan, you have certain rights and responsibilities that are outlined below:

You have the right to:

- Receive all the benefits to which you are entitled under your contract.
- Receive quality health care through your providers in a timely manner and medically appropriate setting.
- Considerate, courteous, and respectful care.
- Be treated with respect and recognition of your dignity and right to privacy.
- Information about services, staff, hours of operation, and your benefits, including access to routine services, as well as after-hours and emergency services and members' rights and responsibilities.
- Participate in decision making with your physician about your health care.
- Obtain complete, current information concerning a diagnosis, treatment, and prognosis from a provider in terms that you can reasonably be expected to understand. When it is not advisable to give such information to the enrollee, the information shall be made available to an appropriate person acting on the enrollee's behalf.
- Refuse treatment as allowed by law, and be informed by your physician of the medical consequences.
- Refuse to participate in research.
- Confidentiality of medical records and information, with the authority to approve or refuse the redisclosure by us of such information, to the extent protected by law.
- Receive all information needed to give informed consent for any procedure or treatment.
- Access your medical records as permitted by New York State law.
- Express concerns and complaints about the care and services provided by physicians and other providers, and have us investigate and respond to these concerns and complaints.
- Candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Care and treatment without regard to age, race, color, sex or sexual orientation, religion, marital status, national origin, economic status, or source of payment.
- Voice complaints and recommend changes in benefits and services to staff, administration, and/or the New York State Insurance Department or Department of Health, without fear of reprisal.
- Formulate advance directives regarding your care. To obtain a Health Care Proxy form, please contact us.
- Contact one of our service departments to obtain the names, qualifications, and titles of providers who are responsible for your care.
- All information about your health plan, its services and its providers and procedures.
- Make recommendations regarding the organization's members' rights and responsibilities.

You have the responsibility to:

- Be an active partner in the effort to promote and restore health by:
  - openly sharing information about your symptoms and health history with your physician;
  - listening;
  - asking questions;
  - becoming informed about your diagnosis, recommended treatment and anticipated or possible outcomes;
  - following the plans of care you have agreed to (such as taking medicine, and making and keeping appointments);
  - returning for further care, if any problem fails to improve; and
  - accepting responsibility for the outcome of your decisions.
- Participate in understanding health problems and developing mutually agreed upon treatment goals.
- Have all care provided, arranged, or authorized by your primary care physician (PCP).
- Inform your PCP if there are changes in your health status.
- Obtain services authorized by your PCP.
- Share with your PCP any concerns about the medical care or services that you receive.
- Permit us to review your medical records in order to comply with federal, state, and local government regulations regarding quality assurance, and to verify the nature of services provided.
- Respect time set aside for your appointments with providers and give as much notice as possible when an appointment must be rescheduled or cancelled.
- Understand that emergencies arise for your providers and that your appointments may be unavoidably delayed as a result.
- Respect staff and providers.
- Follow the instructions and guidelines given by your providers.
- Show your ID card and pay your visit fees to the provider at the time the service is rendered.
- Become informed about our policies and procedures, as well as the office policies and procedures of your providers, so that you can make the best use of the services that are available under your contract.
- Abide by the conditions set forth in your contract.

Glossary of Common Health Care Terms

Clinical Peer Reviewer — A physician who possesses a current and valid non-restricted license to practice medicine; or a health care professional who possesses a current and valid certificate, license, or registration or, where no provision for a license, certificate, or registration exists, is accredited by a national accrediting body and who is in the same profession and same or similar specialty as the provider who typically manages the disease or condition at issue.

Designee — An individual that you designate in writing as your authorized agent in dealings with your health insurer.

Non-Participating Provider — Provider who has no agreement to provide contract benefits to our members.

Participating Provider — Provider who has an agreement with us to provide benefits to our members under our contracts.

Primary Care Physician (PCP) — Physician who has signed an agreement with us to be responsible for the coordination of health services for a member who has designated that physician as his or her primary care provider.

Specialist — Physician, not the primary care physician, who is certified to practice in a specified field of medicine.

Treatment Plan — Documentation of health services, such as rehabilitation services or restorative care, necessary to improve a member's health, based on the provider's evaluation and progress of the member.

How To Contact Us

If you need additional information, have questions, or have any concerns, complaints or problems about any aspect of coverage, you should contact Customer Service.

- If you have chosen a PCP, please use the Customer Service phone number listed on your ID card.
- If you have not chosen a PCP, please use the Customer Service phone number listed under the county that you live in.

Customer Service and Other Important Phone Numbers

Rochester Region (Monroe, Livingston, Ontario, Seneca, Wayne and Yates Counties)

- We can be reached Monday through Thursday from 8:00 am to 5:00 pm and Friday from 9:00 am to 5:00 pm at the number listed on your identification card or toll-free at:.....1-800-650-4359
- You can also call our ExpressLine at: 1-585-454-5010
- Our TTY equipment is available for our hearing impaired members at:.....1-585-454-2845
- For questions regarding dental benefits or services call Healthplex at:.....1-800-468-9868

Central New York Region (Onondaga, Broome, Chemung, Cortland Counties)

- We can be reached Monday through Thursday from 8:00 am to 5:00 pm and Friday from 9:00 am to 5:00 pm at the number listed on your identification card or toll-free at.....1-800-282-0068
- Our TTY equipment is available for our hearing impaired members at:.....1-315-448-6764
- For questions regarding dental benefits or services call Healthplex at:.....1-800-468-9868

Utica Region (Oneida, Herkimer, St. Lawrence, Clinton, Franklin, Essex, Madison)

- We can be reached Monday through Thursday from 8:00 am to 5:00 pm and Friday from 9:00 am to 5:00 pm at the number listed on your identification card or toll-free at:.....1-800-650-4359
- Our TTY/TDD equipment is available for our hearing impaired members at: 1-315-798-4384
- For questions regarding dental benefits or services call Healthplex at:.....1-800-468-9868

If you need to file a grievance or appeal under circumstances in which a delay would significantly increase the risk to your health, you may call us at the above numbers at any time, 24 hours a day, seven days a week.

You may also find the information you need at our Website: http://www.excellusbcbs.com

Submitting a Claim

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

If you need a claim form simply call the Express Line in the Rochester area at 1-585-454-5010 or visit our Website. Complete the form and attached the itemized bill you received from the provider. You may also obtain a claim from by speaking with a Customer Service representative at any of the above numbers.

You may also write or visit us in person at:

Rochester Office
165 Court Street
Rochester, NY 14647

Syracuse Office
333 Butternut Drive
Syracuse, NY 13214

Utica Office
12 Rhoads Drive
Utica, NY 13502

Fraud and Abuse We have established fraud and abuse hotlines that operate 24 hours a day. If you have reason to suspect fraud or abuse, feel free to call: Toll Free: 1-800-378-8024

Visit us Online at www.excellusbcbs.com

Our Website makes it easy for you to do business with us. From updating your policy, changing your doctor or requiring a new ID card to getting answers to your questions, our Website is an to your busy day or night!

Visit us online to:
- Change your address or phone number
- Find a doctor using our online provider directory
- Request a new ID card
- Change your doctor
- Store your family's health information online for quick access in an emergency
- Research your health and fitness questions

And more! There's no better time to click with us!

We hope the information contained in this member handbook is helpful to you. Our members consistently give us high marks for customer satisfaction and we are confident that your experience as a member will also be positive.

NEW YORK STATE EXTERNAL APPEAL APPLICATION

Complete and send this application within 4 months of the plan's final adverse determination for health services if you are the patient or the patient's designee, or within 60 days if you are a provider appealing on your own behalf to DFS.

Mail to: New York State Department of Financial Services, 99 Washington Avenue, Box 177, Albany, NY 12210
or Fax to: (800) 332-2729. For help, call (800) 400-8882 or email externalappealquestions@dfs.ny.gov.

1. Applicant Name:				
2. Patient Name:				
Date of Birth:	Gender: ☐ Male ☐ Female ☐ Non-Specified			
3. Patient Address:	Street:			
	City:	State:	Zip Code:	
4. Patient Phone Number:	Primary: ( )	Secondary: ( )		
5. Patient Email Address:				
6. Patient Health Plan:		ID #:		
7. Patient's Physician/Prescriber:				
8. Physician/Prescriber Address:	Street:			
	City:	State:	Zip Code:	
9. Physician/Prescriber Phone #:	( )	Fax:	( )	
10. If the patient has a Medicaid Managed Care Plan, has patient requested a fair hearing through Medicaid or received a fair hearing determination?	☐ Yes	☐ No	☐ Don't know	

11. To be completed if the applicant is the patient's designee

Complete this section only if a designee is submitting this appeal on a patient's behalf. If the patient's provider is the designee complete section 14 instead of this section.

Name of Designee:			
Relationship to Patient:			
Address:	Street:		
	City:	State:	Zip Code:
Phone Number:	( )	Fax:	( )
Designee Email Address:			

12. **Reason for Health Plan Denial** - check only one and **attach** a completed physician's attestation for all expedited appeals and all denial reasons except for Not Medically Necessary:

☐ Not medically necessary	☐ Experimental/investigational for a clinical trial
☐ Experimental/ investigational	☐ Experimental/investigational for a rare disease
☐ Out-of-network and the health plan proposed an alternate in-network service	☐ Out-of-network referral
☐ Formulary Exception (for individual and small group coverage, other than Medicaid or Child Health Plus)	

13. This appeal may be expedited. Expedited decisions are made within the timeframes described below, even if the patient, physician or prescriber does not provide needed medical information to the external appeal agent.		
If Expedited check one:	☐ Expedited Appeal (72 hours). Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized.	
	☐ Expedited Appeal (72 hours). 30-day timeframe will seriously jeopardize patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient's health, and patient's physician will complete the Physician Attestation and send it to the Department of Financial Services.	
	☐ Expedited Formulary Exception (24 hours). The patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug, and patient's prescribing physician or other prescriber will complete the Physician Attestation and send it to the Department of Financial Services.	
If Standard check one:	☐ Standard Formulary Exception (72 hours)	☐ Standard Appeal for all other appeals (30 days)

***** If expedited you must call 888-990-3991 when the application is faxed*****

14. To be completed if applicant is patient's provider

Health care providers have a right to an external appeal of a concurrent or retrospective final adverse determination. This section should be completed by providers appealing on their own behalf or appealing as a patient's designee. The initial denial and final adverse determination from the first level of appeal must be attached.

☐ Provider filing own behalf	☐ Provider filing as designee on behalf of patient		
Provider Name:			
Person or Firm Representing Provider (if applicable):			
Contact Person for Correspondence:			
Address for Correspondence:	Street:		
	City:	State:	Zip Code:
Phone Number:	( )	Fax:	( )
Email Address:			

I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree not to pursue reimbursement for the service from the patient if a concurrent denial is upheld by the external appeal agent, except to collect a copayment, coinsurance or deductible. If I appeal a concurrent denial on my own behalf, and not as the patient's designee, I agree to pay the external appeal agent's fee in full if the health plan's concurrent denial is upheld, or to pay half of the agent's fee if the health plan's concurrent denial is upheld in part. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against the health plan.

Provider Signature:	

15. Description and date(s) of Service: (Attach any additional information you want considered):	
16. External Appeal Eligibility (Check one):	
	☐ Attached is final adverse determination from the health plan.
	☐ Attached is the health plan's letter waiving an internal appeal.
	☐ Patient requests expedited internal appeal at same time as the external appeal.
	☐ Health plan did not comply with internal appeal requirements for patient appeal.
17. External Appeal Fee	
You must enclose a check or money order made out to the health plan if required by the health plan. If the appeal is decided in your favor, the fee will be returned to you.	
Please check one:	☐ Enclosed is a check or money order made out to the health plan.
	☐ Application was faxed and fee will be mailed to the Department within 3 days.
	☐ Patient is covered under Medicaid or Child Health Plus.
	☐ Patient requests fee waiver for hardship and will provide documentation to the health plan.
	☐ Health plan does not charge a fee for an external appeal or fee is not required.

PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NEW YORK STATE EXTERNAL APPEAL

The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans.

When an external appeal is filed, a consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol / substance use treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

If the patient or the patient's designee submits this application, by signing the Patient Consent to the Release of Records for New York State External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

Signature of patient is required below. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased, the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, power of attorney, healthcare proxy or executor, a copy of the legal supporting document should be included.

Signature:			
Print Name:			
Relationship to patient, if applicable:			
Patient Name:		Age:	
Patient's Health Plan ID#:			
Date: (required)			

PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

The patient's physician must complete this attestation for any external appeal of a health plan's denial of services as experimental/investigational; a clinical trial; a rare disease; out-of-network; or for an expedited appeal. The patient's prescriber may also request an expedited formulary exception appeal. The Department of Financial Services or the external appeal agent may need to request additional information from you, including the patient's medical records. This information should be provided immediately.

Mail to: New York State Department of Financial Services, 99 Washington Avenue, Box 177, Albany NY, 12210
or Fax to: (800) 332-2729.

Type of Review Requested:	☐ Standard Appeal (30 days), or for a non-formulary drug (72 hours)	☐ Expedited Appeal (72 hours), or for a non-formulary drug (24 hours)
If Expedited check one:	☐ Expedited Appeal (72 hours). Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized. ☐ Expedited Appeal (72 hours). 30-day timeframe will seriously jeopardize patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient's health. ☐ Expedited Formulary Exception (24 hours). The patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug.	
If Expedited complete both:	☐ I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 72 hours (or 24 hours for a non-formulary drug) of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.	
	During non-business days, I can be reached at: ( )	

- For an **expedited appeal**, the patient's physician, or for a non-formulary drug, the patient's prescribing physician or other prescriber, must complete the box below and item **14**. **You must send information to the agent immediately in order for it to be considered.**
- For an **experimental/investigational** denial (other than a clinical trial or rare disease treatment) the patient's physician must complete items **1-10 and 14**.
- For a **clinical trial** denial, the patient's physician must complete items **1-9, 11 and 14**.
- For an **out-of-network service** denial (the health plan offers an alternate in-network service that is not materially different from the out-of-network service), the patient's physician must complete items **1-10 and 14**.
- For an **out-of-network referral** denial (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient), the patient's physician must complete items **1 - 9, 13 and 14**.
- For a **rare disease** denial, a physician, other than the treating physician, must complete items **1-9, 12 and 14**.

1. Name of Physician (or Prescriber) completing this form:	
To appeal an experimental/investigational, clinical trial, out-of-network service, or out-of-network referral denial, the physician must be licensed and board-certified or board-eligible and qualified to practice in the area of practice appropriate to treat the patient. For a rare disease appeal, a physician must meet the above requirements but may not be the patient's treating physician.	

2. Physician (or Prescriber) Address:	Street:		
	City:	State:	Zip Code:
3. Contact Person:			
4. Phone Number:	( )	Fax:	( )
5. Physician (or Prescriber) Email:			
6. Name of Patient:			
7. Patient Address:			
8. Patient Phone Number:			
9. Patient Health Plan Name and ID Number:			

10. Experimental/Investigational Denial or Out-of-Network Service Denial
(Complete this section for an experimental/investigational denial or an out-of-network service denial only. DO NOT complete this item for appeal of clinical trial participation, rare disease, or an out-of-network referral denial.)

a. For an Experimental/Investigational Denial:

As the patient's physician I attest that (select one without altering):

OR	☐ Standard health services or procedures have been ineffective or would be medically inappropriate.
	☐ There does not exist a more beneficial standard health service or procedure covered by the health plan.
AND	☐ I recommended a health service or pharmaceutical product that, based on the following **two** documents of medical and scientific evidence **outlined in c and d below**, is likely to be more beneficial to the patient than any covered standard health service.

b. For an Out-of-Network Service Denial

☐ As the patient's physician I attest that the following out-of-network health service (identify service):

is materially different from the alternate in-network health service recommended by the health plan and (based on the following **two** documents of medical and scientific evidence) is likely to be more clinically beneficial than the alternate in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

c. List the documents relied upon and attach a copy of the documents:

Document #1 Title:					
Publication Name:		Issue Number:		Date:	
Document #2 Title:					
Publication Name		Issue Number:		Date:	

d. Supporting Documents		
The medical and scientific evidence listed above meets one of the following criteria (Note: peer-reviewed literature does not include publications or supplements sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.)		Check the applicable documents:
☐	Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and MEDLARS database Health Services Technology Assessment Research;	☐ Document #1 ☐ Document #2
☐	Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;	☐ Document #1 ☐ Document #2
☐	Peer-reviewed abstracts accepted for presentation at major medical association meetings;	☐ Document #1 ☐ Document #2
☐	Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act;	☐ Document #1 ☐ Document #2
☐	The following standard reference compendia: (i) the American Hospital Formulary Service Drug Information; (ii) the National Comprehensive Cancer Network's Drugs and Biological Compendium; (iii) the American Dental Association Accepted Dental Therapeutics; (iv) Thomson Micromedex DrugDex; or (v) Elsevier Gold Standard's Clinical Pharmacology; or other compendia as identified by the Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal;	☐ Document #1 ☐ Document #2
☐	Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.	☐ Document #1 ☐ Document #2

11. Clinical Trial Denial	
☐	There exists a clinical trial which is open and for which the patient is eligible and has been or will likely be accepted.

Although not required, it is recommended you enclose clinical trial protocols and related information. The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified non-governmental research entity as identified in guidelines issued by individual NIH Institutes for Center Support Grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

12. Rare Disease Treatment Denial

If provision of the service requires approval of an Institutional Review Board, include or attach the approval.

☐	As a physician, other than the patient's treating physician, I attest the patient has a rare condition or disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service. The requested service is likely to benefit the patient in the treatment of the patient's rare disease, and such benefit outweighs the risk of the service.

☐ I do ☐ I do not have a material financial or professional relationship with the provider of the service (check one).

Check one:	☐ The patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.
	☐ The patient's rare disease affects fewer than 200,000 U.S. residents per year.

13. Out-of-Network Referral Denial

As the patient's attending physician, I certify that the in-network health care provider(s) recommended by the health plan do not have the appropriate training and experience to meet the particular health care needs of the patient. I recommend the out-of-network provider indicated below, who has the appropriate training and experience to meet the particular health care needs of the patient and is able to provide the requested health service.

Name of out-of-network provider:	
Address of out-of-network provider:	
Training and experience of out-of-network provider: (e.g., board certification, years treating the condition, # of procedures performed and outcome, any other pertinent information).	

14. Physician (or Prescriber) Signature

I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

Signature of Physician (or Prescriber):		Date:	
Physician (or Prescriber) Name: (Print Clearly):			

HELPFUL HINTS FOR COMPLETING THE EXTERNAL APPEAL APPLICATION

Some sections of the application can be confusing. This will help explain what is expected for those sections.

Application

- Number 11 is only required if the patient has designated someone other than the provider to act on their behalf.
- Number 12 indicates the reason the health plan denied the service. This information is found on the Final Adverse Determination (denial letter) from the health plan.
- The Type of Review must be completed in number 13 if an expedited appeal is being requested. External Appeals can only be expedited if the denial falls into one of these categories. If you already received the services your appeal cannot be expedited. You must also indicate if this is for a Standard Formulary Exception or a Standard External Appeal.
- Number 14 is required if the provider is submitting the application on their own behalf or behalf of the patient.
- Number 15 is to be used to describe the services requested. You can attach a separate document with this information.
- Number 17 relates to the fee that a health plan may charge for the external appeal. The final adverse determination will indicate if the health plan charges a fee.
- Patient Consent to the Release of Records for NYS External Appeal – this document must be signed by the patient or their authorized representative. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, healthcare proxy or executor, a copy of the legal supporting document should be included.

Physician's Attestation

- For medical necessity, experimental/investigational, and out-of-network appeals, the first section is required if the attending physician is requesting an expedited appeal because the standard 30-day timeframe would jeopardize the patient's life, health or ability to regain maximum function, or the delay would pose an imminent or serious threat to the patient's health. The attending physician must also include a phone number where they can be reached during non-business hours. This is important since the External Appeal Agent must make a determination within 72 hours of receipt. The decision must be issued even in the event of incomplete medical information or unanswered questions due to the inability to reach the attending physician.
- For formulary exception appeals, the first section is required if the attending physician or prescriber is requesting an expedited appeal because the patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug. The attending physician or prescriber must also include a phone number where they can be reached during non-business hours. This is important since the External Appeal Agent must make a determination with 24 hours of receipt. The decision must be issued even in the event of

incomplete medical information or unanswered questions due to the inability to reach the attending physician/prescriber.

- Number 10 is required for Experimental/Investigational and Out-of-Network Service denials (where the health plan offers an alternate in-network service that is not materially different from the out-of-network service). Subsections a, c and d are required when appealing an experimental/investigational denial.
    - Subsections b, c and d are required for Out-of-Network Service denials.
    - Subsection c. must include information on the medical and scientific evidence (clinical peer reviewed literature) that supports the service requested for the patient's condition. Two articles are required. This section MUST be completed in full, "See attached" will not suffice. The documents that are acceptable for submission are described in subsection d. There is no requirement that the two documents be from different categories.
- Number 11 is required for coverage in a clinical trial. Please note, the Affordable Care Act requires coverage of routine patient costs associated with approved clinical trials. This requirement does NOT apply to grandfathered health plans.
- Number 12 is required for the Experimental/Investigational denials for treatment of a rare disease. The physician signing the attestation for treatment of a rare disease cannot be the patient's attending physician. They must disclose any relationship with the patient's attending physician and indicate which definition of "rare disease" applies to the patient's condition.
- Number 13 must be completed for out-of-network referral denials (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient). The name and address of the out-of-network provider must be included as well as their training and experience. The information provided will be used by the clinical peer reviewer when comparing the qualifications of the in-network provider(s) to the out-of-network provider. Information such as the out-of-network provider's curriculum vitae, Board certification, number of years of experience treating the condition, the number of times the out-of-network provider has performed the requested procedure and the outcomes of those procedures, and any other relevant information should be provided. This information may be provided in an attachment to the application.
- Number 14 must be signed by a Physician. Physician is defined in NYS Education law as an MD or DO. Attestations signed by any other provider will not be accepted. For formulary exception appeals, #14 may be signed by a physician or prescriber.

Excellus

New York State's Health Plan for Kids

This is your

Child Health Plus Contract

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This is your Child Health Plus Contract with Excellus Health Plan, Inc. This Contract will continue unless it is terminated for any of the reasons described in the Contract.

Important Notice. All care covered under this Contract (including hospitalization) must be provided, arranged or authorized in advance by your Primary Care Physician and approved by us. In order to receive benefits under this Contract, you must contact your Primary Care Physician before the services are rendered, except for services to treat an Emergency Condition as described in Section Nine and certain gynecological care described in Sections Five and Seven of this Contract.

This is a special kind of health insurance which only covers children who meet the eligibility requirements for coverage under the New York State Child Health Plus program.

You have the right to return this Contract. Examine it carefully. If you are not satisfied with this Contract, you may return it and ask us to cancel it. Your request must be made in writing and must be made within ten (10) days of the date you receive this Contract. We will refund any premium you paid for this Contract. If you return this Contract, we will not provide you with any benefits.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

EXCELLUS HEALTH PLAN, INC.
doing business as

Upstate HMO
165 Court Street
Rochester, New York 14647

By: Christopher C. Booth

Christopher C. Booth
President and Chief Executive Officer

TABLE OF CONTENTS

SECTION ONE — INTRODUCTION AND DEFINITIONS

1. **Medical Care Through The HMO Concept.** This Contract provides coverage through a Health Maintenance Organization, or HMO for short. In an HMO, all care must be provided, arranged or authorized by your Primary Care Physician and approved by us, including your expenses for care in a hospital. A "Primary Care Physician" is a physician selected by each person covered under this Contract from a list of Primary Care Physicians to provide and coordinate services covered by this Contract. Each person covered under this Contract must select a Primary Care Physician from the list of providers offered with this Contract. In addition, each female requiring OB/GYN services should select a participating obstetrician/gynecologist as her secondary PCP. You may access primary and preventive gynecological services, care related to a pregnancy or acute gynecological condition directly from this secondary PCP. Except in the case of certain gynecological services (see Sections Five and Seven) and in the case of an Emergency Condition (see Section Nine), we will not pay any benefits under this Contract unless the care is provided, arranged or authorized by your Primary Care Physician and approved by us before the services are rendered.

2. **Your Coverage Under This Contract.** This Contract establishes a legal relationship between you and Excellus Health Plan, Inc. You are entitled to receive only the benefits described in this Contract. You should keep this Contract with your other important papers so that it is available for your future reference.

3. **Definitions.**

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

   B. **Effective Date.** The date your coverage under this Contract begins. Coverage begins 12:01 a.m. on the Effective Date.

   C. **Facility.** A hospital; ambulatory surgery facility; dialysis center; an institutional provider of mental health or chemical abuse treatment operating under Article 31 of the New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or other provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable).

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

   E. **Medical Necessity.** See Section Three.

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

   G. **Non-Participating Provider.** A Professional Provider or Facility that does not have an agreement with us to provide health services to Members.

   H. **Participating Pharmacy.** Any pharmacy which regularly dispenses prescription drugs and has entered into a participation agreement with us.

   I. **Participating Provider.** A Professional Provider or Facility that has an agreement with us to provide health services to Members.

   J. **Primary Care Physician (PCP).** A Participating Provider who has an agreement with us to provide primary health care services to Members, subject to the Participating Provider's acceptance of the Member; who has agreed to be responsible for providing or arranging the Member's care; and who maintains the Member's medical records.

   K. **Service Area.** The geographic area in which we will arrange and provide benefits to our members.

   L. **Skilled Care.** A service, which 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 which cannot be safely and adequately self-administered or performed by the average non-medical person without the supervision of such personnel.

   M. **Subscriber.** The individual to whom this Contract is issued.

   N. **Treatment Plan.** The documentation of health services, such as rehabilitation services or restorative care, necessary to improve a member's health, based on the provider's evaluation and progress of the member.

O. **"We", "Us" or "Our" and "You", "Your" and "Yours".** Throughout this Contract, Excellus Health Plan, Inc., will be referred to as "we", "us" or "our". The word "you", "your" or "yours" refers to you, the Subscriber.

SECTION TWO — WHO IS COVERED

1. **Who is Covered Under this Contract.** You, the child to whom this Contract is issued, are covered under this Contract. In order to be covered under this Contract you must meet all the criteria listed below:

   A. You must be under the age of 19.

   B. You must not have other health care coverage.

   C. You must not be eligible for the Medicaid program.

   D. You must be a permanent New York State resident and a resident of our Service Area.

   When you apply for this Contract we will review your application form to determine if you meet the New York State Child Health Plus eligibility criteria.

   EACH YEAR YOU MUST RESUBMIT THE APPLICATION TO US SO THAT WE CAN DETERMINE IF YOU STILL MEET THE NEW YORK STATE MANDATED CHILD HEALTH PLUS ELIGIBILITY REQUIREMENTS.

SECTION THREE — MEDICAL NECESSITY

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

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

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

   A. reports in peer reviewed medical literature;

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

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

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

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

   F. any other relevant information brought to our attention.

   Services will be deemed Medically Necessary only if:

   A. they are appropriate and consistent with the diagnosis and treatment of your medical condition;

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

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

   D. they are provided in accordance with community standards of good medical practice;

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

   F. they are the most appropriate Service and rendered in the most efficient and economical way and at the most economical level of care which can safely be provided to you; and

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

2. **Service or Care Must Be Approved Standard Treatment.** Except as otherwise required by law, no service or care rendered to you will be considered Medically Necessary unless we determine, in our sole judgment, the service or care is consistent with the diagnosis and treatment of your medical condition; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative. Please see Section Fourteen, Paragraph 24 for your right to an external appeal of our determination that service or care is not Medically Necessary.

SECTION FOUR — INPATIENT CARE

1. **Care in a Facility.** If you are a registered bed patient in a Facility, we will provide In-network coverage for most of the services provided by the Facility, if all of the conditions set forth below are met:

   A. The Facility is a "Member Facility". A Member Facility is a Facility that has an agreement with us to provide services to persons covered under our HMO contracts;

   B. Your admission is authorized by your Primary Care Physician and approved by the Medical Director before you enter the Facility (when you are admitted as an inpatient through the emergency room of a hospital, you must call your Primary Care Physician within 48 hours of admission, or as soon as reasonably possible);

   C. While in the Facility you remain under the care of your Primary Care Physician or another physician designated by your Primary Care Physician;

   D. The Facility is located in our Service Area; and

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

   You do not have to meet all of the conditions described above for an admission to a hospital to treat an Emergency Condition. See Section Nine.

2. **Care in a Facility Other Than a Member Facility.** We will provide coverage in a Facility that is not a member Facility under the following conditions:

   A. If you did not receive care in the other Facility, you would have to be cared for in the inpatient or outpatient department of a member Facility. In other words, your Primary Care Physician and our Medical Director determine that care in the other Facility is a substitute for care in a member Facility.

   B. In the judgment of your Primary Care Physician and the Medical Director, you would receive care more appropriate to the treatment of your condition in a Facility other than a member Facility. Generally, this is care of a more specialized nature than would be given in a member Facility.

   C. The Facility is one designated by your Primary Care Physician and the Medical Director and has an agreement with us with respect to reimbursement.

   D. Care in the Facility will be provided only for as long as you would otherwise have been confined in a member Facility.

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

   A. Special duty nurses;

   B. Private room, unless in our sole judgment, it is Medically Necessary for you to occupy a private room;

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

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

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

   F. Custodial care. (See Section Ten, Paragraph 7.)

4. **Number of Days of Care.** We will provide coverage for care in a member Facility, or other Facility, under the conditions described on any day we determine that hospitalization was Medically Necessary for the care or treatment of your condition, illness or injury subject to the limitations described in Paragraph 5 below. We will not provide coverage after a date we determine that hospitalization was no longer Medically Necessary.

5. **Limitations on Number of Days of Care - Inpatient Mental Health Care, Inpatient Rehabilitation for Chemical Abuse and Inpatient Diagnosis and Treatment of Chemical Dependence (Detoxification).** We will provide coverage for hospitalization which, in the judgment of your Primary Care Physician and our Medical Director, is for mental care, rehabilitation for chemical abuse or active treatment for detoxification needed because of chemical dependence, for up to an aggregate of 30 days in a Calendar Year.

6. **Maternity Care.** We will provide coverage for inpatient maternity care in a hospital for the mother 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 which we determine are Medically Necessary. In the event the mother elects to leave the hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum coverage period, we will provide coverage of the home care visit furnished by the type of home care agency described in Section Six of this Contract.

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 the visit limit described in Section Six of this Contract.

7. **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 attending physician. We will also provide coverage for prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

SECTION FIVE — OUTPATIENT CARE

We will provide coverage for the same services we would provide if you were an inpatient in connection with the care described below when given to you as an outpatient in a Facility. As in the case of inpatient care, the service must be authorized in advance by your Primary Care Physician and approved by the Medical Director. The care 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 provide coverage for care in connection with surgery.

   See Section Seven for a description of outpatient physician surgical services.

2. **Pre-Admission Testing.** We will provide coverage for tests ordered by your physician which are given to you as a preliminary to your admission to the hospital 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. You have made a reservation for the hospital bed and/or the operating room before the tests are given;

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

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

3. **Diagnostic Procedures.** We will provide coverage for diagnostic procedures, including x-rays and laboratory procedures.

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

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

6. **Cervical Cytology Screenings (Pap Smears).** We will provide coverage for an annual screening for cervical cancer and its precursor states for women aged eighteen and for females of any age who are sexually active. The screenings may be provided in the outpatient department of a hospital under this Section or in a physician's office pursuant to Section Seven, Paragraph 11. Cervical cytology screening shall mean an annual pelvic examination; collection and preparation of a Pap smear; and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

   You may obtain the screenings from a Participating Provider without obtaining an approved referral from your PCP.

7. **Mental Health and Chemical Dependence Visits.** We will provide coverage for up to an aggregate of 60 visits for mental health visits and chemical dependence visits in a Calendar Year for evaluation and short-term treatment, for conditions which can be expected to result in significant improvement within a relatively short period of time, based on our clinical guidelines. Your provider must submit a Treatment Plan to us before we will approve services beyond the initial consultation. Visits may be used for family therapy if related to the treatment of a family member's alcoholism or substance abuse.

   This service may be provided in a physician's office pursuant to Section Seven, Paragraph 13 or in the outpatient department of a hospital pursuant to this section.

   Our coverage of mental health and chemical dependence visits under this section and under Section Seven, Paragraph 13, are subject to an aggregate limit of 60 visits per Calendar Year.

8. **Physical and Occupational Therapy.** We will provide coverage for up to an aggregate of 20 visits per condition per Calendar Year for physical and occupational therapy when we determine, in our sole judgment, that your condition is subject to significant clinical improvement through relatively short-term therapy. Your provider must submit a Treatment Plan to us before we will approve any services beyond the initial consultation.

   Our coverage of physical and occupational therapy visits under this section and under Section Seven, Paragraph 15, are subject to an aggregate limit of 20 visits per condition per Calendar Year.

SECTION SIX — HOME CARE

1. **Home Care Benefit.** We will provide coverage for home care visits given by a Participating home health agency or a home care services agency if your Primary Care Physician and our Medical Director determine that the visits are Medically Necessary. The visits may include the following:

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

   B. Part-time or intermittent home health aide services which consist of primarily rendering direct care to you;

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

   D. Medical supplies, drugs, and medications prescribed by your physician; and laboratory services by or on behalf of the home health agency or home care services agency to the extent such items would have been covered under this Contract if you were an inpatient in a hospital or skilled nursing facility.

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

   A. A home care Treatment Plan must be established and approved in writing by your Primary Care Physician. Your Primary Care Physician must obtain approval from our Medical Director before arranging for visits in your home; and

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

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

4. **Number of Days of Care.** We will provide coverage for 40 home care visits per Calendar Year. A visit consists of up to four hours of continuous home health aide care.

SECTION SEVEN — PROFESSIONAL SERVICES

We will provide coverage for the services of Professional Providers described below. Unless otherwise specified, care must be provided by your Primary Care Physician or by another Participating Provider pursuant to an approved referral.

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

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

   We will provide coverage for a physician to assist your surgeon when we determine the assistance of the second physician is necessary. There must be no qualified house staff available to assist your surgeon.

2. **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 Contract.

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

   A. We will provide benefits when:

      (1) you seek the second surgical opinion after your Primary Care Physician determines your need for surgery; and

      (2) the second surgical opinion is rendered by a Participating Provider who is a board certified specialist; and who, by reason of his or her specialty, is an appropriate physician to consider the proposed surgical procedure; and

      (3) the second surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under this Contract if such surgery was performed; and

(4) you are examined in person by the Participating Provider rendering the second surgical opinion.

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

4. **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 physician as having some form of cancer. A negative diagnosis of cancer occurs when your physician performs a cancer screening exam on you and finds that you do not have cancer, based on the exam results. We will also provide coverage for a second medical opinion concerning any recommendation of a course of treatment for 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. The specialist rendering the second medical opinion must be a Participating Provider to whom you have received an approved referral, unless you have received an approved referral from your Primary Care Physician to a Non-Participating Provider.

5. **Maternity Care.** We will provide coverage for:

A. **Normal Pregnancy.** Maternity care includes the first visit upon which a positive pregnancy test is determined. It also includes all subsequent prenatal and postpartum care. These benefits include the services of a licensed midwife, under qualified medical direction, affiliated or practicing in conjunction with a facility licensed under the New York Public Health Law. You do not need an approved referral from your Primary Care Physician for maternity care; however, the care must be received from a Participating Provider.

B. **Complications of Pregnancy and Termination.** We will provide coverage for complications of pregnancy and non-elective termination of pregnancy, including non-elective Caesarean sections.

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

6. **In-Hospital Medical Services.** We will provide coverage for medical visits provided, arranged or authorized by your Primary Care Physician on any day of hospitalization covered under Section Four. We will not provide coverage for medical visits by hospital employees or interns.

The provider's services must be documented in the hospital records. We will cover only one visit per day per provider.

7. **Medical Care In a Physician's Office.** You are entitled to the following services at a Participating Provider's office when the service is provided, authorized, or arranged by your Primary Care Physician.

A. **Preventive Health Services.** We will provide coverage for well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics, as well as necessary immunizations as determined by the Superintendent of Insurance in consultation with the Commissioner of Health.

We will provide coverage for 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.

We will provide coverage for screenings for sexually transmitted diseases in accordance with the schedule of the American Academy of Pediatrics for sexually active Members.

B. **Other Health Services.**

We will provide coverage for diagnostic laboratory and pathology services.

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

8. **Diagnostic Imaging Examinations and Diagnostic Radioactive Isotope Procedures.** We will provide coverage for the professional component of x-ray examinations; radioactive isotope; ultrasound; CAT scan; and magnetic resonance imaging procedures provided by Participating Providers.

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

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

11. **Gynecological Services.** We will provide coverage for gynecology visits for women aged eighteen, including coverage for screenings for cervical cancer and its precursor states. The screenings may be provided in the outpatient department of a hospital pursuant to Section Five, Paragraph 6 or in a doctor's office pursuant to this Section. Cervical cytology screening shall mean an annual pelvic examination; collection and preparation of a Pap smear; and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

You may obtain benefits for up to two annual examinations for primary and preventive gynecologic care and gynecologic care required as a result of such annual examinations or as a result of an acute gynecologic condition from a Participating Provider without obtaining an approved referral from your Primary Care Physician.

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

13. **Mental Health and Chemical Dependence Visits.** We will provide coverage for up to an aggregate of 60 mental health visits and chemical dependence visits, in a Calendar Year for evaluation and short-term treatment for conditions which can be expected to result in significant improvement within a relatively short period of time, or for the medical management of mental illness. Your provider must submit a Treatment Plan to us before we will approve In-network services beyond the initial consultation.

    This service may be provided in the outpatient department of a hospital pursuant to Section Five, Paragraph 7 or in a doctor's office pursuant to this Section. Our coverage of mental health and chemical dependence visits under this section and under Section Five, Paragraph 7, are subject to an aggregate limit of 60 visits per calendar year.

14. **Inpatient Consultations.** We will provide coverage for consultations billed by a Participating Provider 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 consultation takes place while you are a registered bed patient in a hospital;

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

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

    E. The consulting physician enters a written report in your hospital records.

15. **Physical and Occupational Therapy.** We will provide coverage for up to an aggregate of 20 visits per condition per Calendar Year for physical and occupational therapy when we determine, in our sole judgment, that your condition is subject to significant clinical improvement through relatively short-term therapy. Your provider must submit a Treatment Plan to us before we will approve any services beyond the initial consultation.

    Our coverage of physical and occupational therapy visits under this section and under Section Five, paragraph 8, are subject to an aggregate limit of 20 visits per condition per Calendar Year.

16. **Speech and Hearing.** We will provide coverage for speech and hearing services. These services include one hearing examination per Calendar Year to determine the need for corrective action. Speech therapy required for a condition amenable to significant clinical improvement within a two month period, beginning with the first day of therapy, will be covered when performed by a participating audiologist, language pathologist, speech therapist, and/or otolaryngologist.

17. **Eye Examinations.** We will provide coverage for one vision examination per Calendar Year (or more frequently if required and supported by appropriate documentation) provided by participating physicians or optometrists for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses.

SECTION EIGHT — ADDITIONAL BENEFITS

We will provide coverage for the services of Participating Providers described below. All care must be provided by your PCP or by another Participating Providers pursuant to an approved referral.

1. **Treatment of Diabetes.** We will provide coverage for the following equipment and supplies for the treatment of diabetes which we determine, in our sole judgment, to be medically necessary and when prescribed or recommended by your Primary Care Physician or other Participating Provider legally authorized to prescribe under Title 8 of the New York State Education Law ("Participating Medical Personnel"). The purchase of insulin pumps and insulin infusion devices must be authorized in advance by your Primary Care Physician and approved by the Medical Director:

    - insulin and oral agents for controlling blood sugar (limited to a 34-day supply when purchased at a retail pharmacy, or a 90-day supply when purchased at a mail order pharmacy);
    - blood glucose monitors;
    - blood glucose monitors for the visually impaired;
    - data management systems;
    - test strips for glucose monitors, visual reading and urine testing;
    - injection aids;
    - cartridges for the visually impaired;
    - insulin pumps and appurtenances thereto;
    - insulin infusion devices; and

- additional medically necessary equipment and supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

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

We will also pay for disposable syringes and needles used solely for the injection of insulin. We will not pay for reusable syringes and needles or multi-use disposable syringes or needles, alcohol swabs, skin care preps, non-prescription hypoglycemic products and batteries.

We will pay for diabetes self-management education and diet information provided by your Primary Care Physician in connection with Medically Necessary visits upon the diagnosis of diabetes, a significant change in your symptoms, the onset of a condition necessitating changes in self-management or where re-education or refresher education is Medically Necessary, as determined by us.

When such education is provided as part of the same office visit or diagnosis or treatment of diabetes, payment for the office visit shall include payment for the education. We will also pay for home visits, when medically necessary.

Education is also covered when provided by the following Participating Providers upon an approved referral from your Primary Care Physician or other Participating Medical Personnel: Certified Diabetes Nurse Educator, Certified Nutritionist, Certified Dietician or Registered Dietician or other provider as required by law. Such education must be provided in a group setting, when practicable.

2. **Durable Medical Equipment.** We will provide coverage for the rental, purchase, repair, or maintenance of durable medical equipment (for example, respirators, canes, crutches, walkers, wheelchairs, trusses, apnea monitors, oxygen-related equipment, special hospital-type beds, or home dialysis units) due to normal wear or body growth. The Medical Director will determine Medical Necessity and whether the item should be purchased or rented.

   Durable medical equipment is equipment that can withstand repeated use, i.e., could normally be rented and used by successive members; 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.

   Not included in this benefit are: the cost of rental, purchase, repair, or maintenance of durable medical equipment because of misuse, loss, natural disaster, or theft; or the additional cost of deluxe items, unless approved in advance by the Medical Director We will only pay benefits for durable medical equipment obtained from vendors or suppliers designated by us.

3. **Hospice Services.** We will provide coverage of hospice services provided by a hospice organization certified under Article 40 of the New York State Public Health Law for members certified by a physician to be terminally ill with a life expectancy of six months or less. All services must be provided according to a written plan of care. Hospice services include five visits for family members for bereavement counseling.

4. **Prescription Drugs.** We will provide coverage for drugs, biologicals and compounded prescriptions that can be dispensed only pursuant to a prescription and that are required by law to bear the legend "Caution - Federal Law prohibits dispensing without a prescription", or that are specifically designated by us. The drug or medication must be prescribed by a Participating Provider, and approved by the FDA for the treatment of your specific diagnosis or condition. The drug must also be approved by us as Medically Necessary treatment of the condition for which the drug is prescribed. In certain situations, specific criteria including medical necessity criteria may be established by us and our provider community, defining whether certain drugs will be covered under this Rider. However, if there is a drug that has been approved for the treatment of one type of cancer, we will also pay for this drug for the treatment of other types of cancer, so long as the drug meets the requirements of Insurance Law Section 4303 (q).

   For purposes of this Contract, Prescription Drugs shall also include non-prescription drugs which are authorized by a professional licensed to write prescriptions and which appear in the Medicaid drug formulary.

   Prescription Drugs shall also include Medically Necessary enteral formulas for which a Participating Provider has issued a written order. The written order must state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific method of treatment for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated. We will also pay for modified solid food products for the treatment of certain inherited diseases of amino acid or organic acid metabolism, when provided pursuant to such written order. However, our coverage for modified solid food products is limited to $2,500 per Calendar Year for such benefits.

We will not pay any benefits under this Contract for Prescription Drugs you purchase at a Non-Participating Pharmacy.

A. **Limitations**

1. We will periodically identify certain Prescription Drugs that, for reasons such as cost and possible use for purposes that are not Medically Necessary or appropriate, will only be filled with preauthorization from us. Our list of Prescription Drugs that require preauthorization is subject to periodic review and modification by our Pharmacy and Therapeutics Committee. Preauthorization may be obtained by calling the number on the Member's ID card. A denial of preauthorization or failure to obtain preauthorization will result in a denial of benefits for that prescription. Before having a prescription filled for the first time, you should contact us to inquire if a Prescription Drug requires preauthorization. You may do so by calling the number on your identification card.
2. We will pay for no more than a thirty (30) day supply of a drug purchased at a participating retail pharmacy. Benefits will be provided for drugs dispensed by a participating mail service pharmacy in a quantity of up to a ninety (90) day supply.
3. We reserve the right to limit quantities, day supply, early refill access and/or duration of therapy for certain medications based on acceptable medical standards and/or FDA recommended guidelines.
4. Benefits will be provided for drug refills. However, no benefit will be provided for a refill obtained before the date that you should have exhausted most of your current supply. Benefits for refills will not be provided beyond one year from the original prescription date.
5. Compounded Prescription Drugs will be covered only when they contain at least one ingredient that is a covered legend prescription drug, is Medically Necessary, and is obtained from a Participating Pharmacy that is approved for compounding.
6. A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.
7. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols shall be consistent with standard medical/drug treatment guidelines. The primary goal of such program is to provide our members a quality-focused drug benefit. In the event a use management protocol is implemented, you will be notified in advance.

B. **Exclusions**

1. Drugs that do not by law require a prescription, except as otherwise provided in this Contract.
2. Prescription Drugs that have over the counter non-prescription equivalents, except as otherwise provided under this Contract. Non-prescription equivalents are drugs available without a prescription that contain the same active ingredient as their prescription counterparts.
3. Devices of any type, even though a prescription may be required. This includes therapeutic devices, artificial appliances or similar devices. We will, however, provide coverage for contraceptive devices (including basal thermometers, male and female condoms and diaphragms).
4. Vitamins, or any herbal products except those that require a prescription by law.
5. Drugs that are prescribed or dispensed for cosmetic purposes, such as hair growth or removing wrinkles.
6. Drugs prescribed or dispensed in anticipation of or in connection with transsexual surgery.
7. Drugs that we determine are prescribed for experimental or investigational use; or that are only available to Members who participate in clinical research programs, unless otherwise required to be covered by external review.
8. Drugs for which payment is available under a workers' compensation law or similar legislation. We will not make any payment under this Rider even if you do not receive workers' compensation benefits because a proper or timely claim for benefits under the law was not submitted or you fail to appear at a workers' compensation hearing.

9. Drugs for which payment is covered by mandatory automobile "no-fault" benefits.

10. Drugs or other pharmacy services provided to you pursuant to a referral prohibited by Section 238-a of the New York Public Health Law. (Generally, Section 238-a prohibits providers from making referrals for pharmacy or other services to a provider, pharmacy or facility in which the referring provider or an immediate family member has a financial interest or relationship.)

11. Prescription Drugs to replace those that may have been lost or stolen.

12. Drugs dispensed in unit-dose packaging when bulk packaging is available.

13. Drugs given or administered in a physician's office or in an inpatient or outpatient facility.

14. Administration or injection of any drugs.

15. Drugs dispensed to a Member while a patient in a hospital, nursing home, other institution, or a patient of a home care services agency, except in those cases where the basis of payment by or on behalf of the member to the hospital, nursing home, home care services agency, or other institution does not include services for drugs.

C. **General Conditions**

1. You must present your identification card to a retail pharmacy and include your identification number on the forms provided by the participating mail order pharmacy from which you make a purchase.

2. As a condition precedent to the approval of claims hereunder, each Member authorizes and directs any Participating Pharmacy which furnished benefit hereunder to make available to us information relating to all prescription orders, copies thereof and other records as needed by us for purposes of administering this rider. We shall in every case hold such information and records as confidential.

3. We conduct various utilization management activities designed to ensure appropriate prescription drug usage, to avoid inappropriate usage and to encourage the use of cost effective drugs. Through these efforts, your group and its members, benefit by obtaining appropriate prescription drugs in a cost effective manner. The cost savings resulting from these activities are reflected in the premiums for your coverage. We may, from time to time, also enter into agreements that result in us receiving rebates or other funds ("rebates") directly or indirectly from prescription drug manufacturers, prescription drug distributors or others. Any rebates are based upon utilization of prescription drug products across all of our business and not solely on any one member's or one group's utilization of prescription drugs. Any rebates received by us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of our prescription drug premiums.

   Any such rebates may instead be retained by us, at our discretion, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of subscribers.

4. We shall not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of merchantability), arising out of or in connection with the sale, compounding, dispensing, manufacturing or use of any Prescription Drug whether or not covered under this Contract.

5. We reserve the right to deny benefits for any drug prescribed or dispensed in a manner contrary to normal medical practice.

5. **Prosthetic and Orthotic Appliances.** We will provide coverage for Medically Necessary prosthetic appliances and orthotic devices ordered by a physician. We will not provide coverage for cranial prostheses, dental prostheses (except those made necessary due to accidental injury to sound, natural teeth and provided within twelve months of the accident and dental prostheses needed to treat a congenital disease or anomaly), or orthotic devices prescribed solely for use during sports.

6. **Hearing Aids.** We will provide coverage for hearing aids and batteries. We will also provider coverage for replacement, repairs and maintenance not covered under warranty.

7. **EyeGlasses and Contact Lenses.** We will provide coverage for eyeglasses (lenses and frames) once in any twelve month period, unless required more frequently with appropriate documentation. The eyeglasses must be Medically Necessary to correct visual acuity problems. We will also provide coverage for contact lenses when Medically Necessary.

8. **Prehospital Emergency Services and Transportation.** We will provide coverage for services to evaluate and treat an "emergency condition," as that term is defined in the Emergency Care section of this contract when such services are provided by an ambulance service certified under the Public Health Law. We will also provide coverage for land ambulance transportation to a hospital provided 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 (i) 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; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

   We will not provide coverage for transfers of members between health care facilities. We will not provide coverage for air ambulance transportation.

SECTION NINE — EMERGENCY CARE

1. **Emergency Conditions.** We will provide coverage for care at the emergency room or urgent care center of a Participating Provider or Non-Participating Provider if your illness or condition is considered an Emergency Condition.

   An Emergency Condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (B) serious impairment to such person's bodily functions; (C) serious dysfunction of any bodily organ or part of such person; (D) serious disfigurement of such person.

   Examples of medical conditions which we consider to be Emergency Conditions are heart attacks, poisoning and multiple trauma.

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

2. **Emergency Room Visits.** We will provide coverage for visits of a physician in an emergency room to treat an Emergency Condition.

3. **Authorization for Emergency Services.** If your condition is an Emergency Condition as defined above, you do not need to obtain authorization from your Primary Care Physician prior to receiving care at an emergency room or urgent care center. When you have received emergency room care in our Service Area for an emergency condition, you or a member of your family must notify your Primary Care Physician within 48 hours after you have received emergency care so that your follow-up care can be coordinated by a Participating Provider. If it was not reasonably possible to give notice within 48 hours your emergency room visit will not be denied, however, notice must be given as soon as it is reasonably possible in order for the follow up care to be covered. In addition, if you are admitted from the emergency room to the hospital as a registered bed patient, you or someone acting on your behalf must notify your Primary Care Physician within 48 hours (or as soon as reasonably possible, if later) after the admission.

   If your condition is not an Emergency Condition as defined above, you must contact your Primary Care Physician to obtain authorization prior to receiving care at an emergency room or urgent care center.

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

4. **Non-Participating Providers.** We will provide coverage by a Non-Participating Provider only for as long as your Primary Care Physician and the Medical Director determine that the emergency room care was Medically Necessary and that your medical condition prevented your transfer to a Participating Provider.

SECTION TEN — EXCLUSIONS

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

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

2. **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.

3. **Correction of Structural Imbalance, Distortion or Subluxation.** We will not provide coverage for any service or care 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. This exclusion applies when the nerve interference is the result of or related to distortion; misalignment; or subluxation of or in the vertebral column.

4. **Cosmetic Services.** We will not provide coverage for any services in connection with elective cosmetic surgery which is primarily intended to improve your appearance. Such services may include, but are not limited to, breast reduction or 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 Contract which has resulted in a functional defect. We will also provide coverage for services in connection with reconstructive surgery following a mastectomy, as provided in Section Four.

5. **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.

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 Contract in the absence of a court order;

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

   C. the Medical Director determines, in advance, that the service or care is Medically Necessary and covered under the terms of this Contract.

   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. **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 could be provided by persons without professional skills or training. For example, custodial care includes activities of daily living such as help in walking; getting in and out of bed; bathing; dressing; eating; and taking medicine. Therapies (such as physical therapy or chiropractic care) that are not improving the patient's condition, or that are maintenance/supportive in nature, are inactive, and therefore custodial care.

8. **Dental Care.** We will not provide coverage for any service or care (including anesthesia and inpatient stays) for treatment of the teeth, gums, or structures supporting the teeth; or any form of dental surgery; regardless of the reasons(s) that the service or care is necessary. For example, we will not provide coverage for x-rays, fillings, extractions, braces, prosthetics, correction of impactions, treatments for gum disease, therapy or other treatments related to dental TMJ disorder or dental oral surgery. We will, however, provide coverage for medical treatment that is directly related to an injury or accident involving the jaw or other bone structures adjoining the teeth, provided that the treatment is approved by the Medical Director. In addition, we will provide the benefits set forth in this Contract for service and care for treatment of sound natural teeth provided within twelve 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 the benefits set forth in this Contract for service and care that we determine in our sole judgment is Medically Necessary for treatment due to a congenital disease or anomaly. For purposes of this paragraph, "congenital" means present at birth. We will cover institutional provider services for dental care when we determine there is an underlying medical condition requiring these services.

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

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

11. **Experimental and Investigational Services.** Unless otherwise required by law, we will not provide coverage for any service or care that consists of a treatment, procedure, drug, biological product, or medical device (collectively, "Service"); an inpatient stay in connection with a Service; or treatment of a complication related to a Service; if, in our sole judgment, the Service is experimental or investigational. See Section Fourteen, Paragraph 24 for your right to an external appeal of our determination that a Service is experimental or investigational.

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

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

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

    C. not of proven safety for a 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; and

    E. Published, peer-reviewed, medical literature must provide proof that improvement in health outcomes, as defined in paragraph 3 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 Contract 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.

12. **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 Contract. 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 or by your brother, sister, mother, father, son or daughter; or the spouse of any of them, we will presume that the service or care would have been furnished without charge. You must prove to us that a service or care would not have been furnished without charge.

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

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

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

16. **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.

17. **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 Contract 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 Contract, 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 hospital and other medical expenses you received payment for under the mandatory automobile no-fault coverage.

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

19. **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.

20. **Organ or Bone Marrow Transplant Searches, Screening or Donation.** We will not provide coverage or care for the costs related to searches or screenings for donors of organs or bone marrow to be transplanted, health services rendered to a Member who is donating an organ for transplantation to a person who is not a Member, and health services rendered to a non-member who is donating an organ for transplantation to a Member.

21. **Other Health Insurance, Health Benefits and Governmental Programs.** We will reduce our payments under this Contract by the amount you are eligible to receive for the same service under other health insurance, health benefits plans or governmental programs. Other health insurance includes coverage by insurers, such as Blue Cross and Blue Shield Plans, HMOs or similar programs. Health benefit plans includes any self-insured or non-insured plan such as those offered by or arranged through employers, trustees, unions, employer organizations or employee benefit organizations. Government programs include Medicare or any other federal, state or local programs, except the Physically Handicapped Children's Program or the Early Intervention Program.

22. **Personal Items.** We will not provide coverage for any service or care that is for personal use and not primarily medical in nature, including, but not limited to: radio, telephone, television, air conditioner, humidifier, dehumidifier, air purifiers; beauty and barber services and exercise equipment.

23. **Private Duty Nursing.** 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

24. **Reproductive Procedures.** We will not provide coverage for any service or care related to conception by artificial means, including, but not limited to, fertility drugs, in vitro fertilization, artificial insemination, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cryopreservation of sperm or embryos, intracytoplasmic sperm injection, sperm washing, sperm storage, surrogate parenting (except that benefits will be provided for covered services rendered to a surrogate parent who is covered under this Contract), or other techniques or methods of assisted reproductive technology that may be developed, the intended outcome of which is similar to these procedures, unless otherwise required by law. This exclusion applies but is not limited to the following services: routine examinations; laboratory tests; birth control counseling; genetic counseling; and diagnostic testing for the sole purpose of inducing pregnancy.

25. **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

26. **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 or educational purposes.

27. **Services Starting Before Coverage Begins.** If you are receiving care on the day your coverage under this Contract begins, we will not provide coverage for any service or care you receive:

    A. prior to the first day of your coverage under this Contract; or

    B. on or after the first day of your coverage under this Contract, if that service or care is covered under any other health benefits contract, program, or plan.

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

28. **Skilled Nursing Facility Care.** We will not provide coverage for care in a skilled nursing facility.

29. **Smoking Cessation Programs.** We will not provide coverage for smoking cessation programs.

30. **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 Hospital, because you did not leave the Hospital before the Hospital's discharge time.

31. **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 Contract.

32. **Transportation.** We will not provide coverage for non-emergency ambulance transportation.

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

34. **Traveling.** We will not provide coverage for any service or care received outside the United States, its possessions, Canada, or Mexico.

35. **Unauthorized Services.** Except for emergency care described in Section Nine and certain maternity and gynecologic care described in Sections Five and vision care described in Section Seven, we will not provide coverage for any service or care unless the treatment is performed, authorized or arranged in advance, by your Primary Care Physician and, when required, approved in advance by the Medical Director.

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

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

SECTION ELEVEN — PREMIUMS FOR THIS CONTRACT

1. **The Child Health Plus Program.** The Child Health Plus program is offered by a New York State law which provides funding for children's health insurance. The program is administered by the Department of Health.

   Under the New York State law, you may have to contribute toward the premium for this coverage depending on the gross annual income of your family or household. The amount which you must contribute, if any, is based on the gross annual income of your family or household. Each year you must resubmit an application so that we can determine if you still have to pay the same amount for this Contract. If your income changes during the year, you must notify us so that we can determine if you still have to pay the same amount for this Contract.

2. **Amount of Premiums.** The premiums for this Contract are determined from time to time by our Board of Directors. The premiums must also be approved by the Superintendent of Insurance of the State of New York.

3. **Change in Premiums.** If there is to be an increase or decrease in the premium for this Contract and you are responsible for full payment of your premium as described above, we will give you at least thirty (30) days written notice of the change.

4. **If You are Required to Pay All or a Portion of Your Premium Payment.** If you are required to pay all or a portion of your premium payment as described in Paragraph "1" above, all premiums for this Contract are due in advance. You will not become covered under this Contract until the first premium payment has been paid to us.

   The premium payment is due 30 days in advance of the coverage date. In most instances we will allow you a grace period for the payment of premium. However, for new applicants the premium is due with the application and the second month's premium is due upon receipt of the premium bill.

   If we do not receive payment within the grace period, the coverage under this Contract will terminate as of the last day of the month of the grace period.

5. **Changes in Your Income or Household Size.** You may request that we review your family premium contribution whenever your income or household size changes. You may request a review by calling us at the number on your ID card or by calling the Child Health Plus Hotline at 1-800-698-4543. At that time, we will provide you with the formal documentation requirements necessary to conduct the review. We will re-evaluate your family premium contribution and notify you of the results within 10 business days of receipt of the request and documentation necessary to conduct the review. If the review results in a change in your family premium contribution, we will apply that change no later than 40 days from receipt of the completed review request and supporting documentation.

SECTION TWELVE — TERMINATION OF YOUR COVERAGE

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

1. **Default in Payment of Premiums.**

   A. If you are required to pay all or a portion of your premium as described in Section Eleven, this Contract will automatically terminate as of the date the grace period ends if we do not receive your premium by the end of the grace period. If the premium is not paid by the end of the grace period, you will not receive payment under this Contract for any service given to you after the date the grace period ends.

   B. If you are totally disabled on the date your coverage terminates you will continue to receive payment for certain care (see Paragraph "8" below). After that date no subscriber shall be entitled to any further benefits.

2. **If You No Longer Qualify.** If you no longer meet the Child Health Plus eligibility requirements your coverage will end. Your coverage under this Contract ends on the first day of the month following any event that results in your no longer meeting the Child Health Plus eligibility requirements. We will require you to reapply and provide documentation to us each year to certify you still meet the Child Health Plus eligibility requirements.

3. **When the Child Health Plus Program Terminates.** Your coverage under this Contract will end when the State law which establishes and provides funding for the Child Health Plus program is terminated or the State terminates this Contract.

4. **If You Move Outside Our Service Area.** If you move outside our Service Area, this Contract will terminate. If you move within the State, you may apply for transfer to the Child Health Plus program of the Blue Cross and Blue Shield Plan or another Child Health Plus plan servicing the area to which you move. Upon your request, we will assist in coordinating the transfer of your Child Health Plus coverage.

5. **On Your Death.** This Contract will automatically terminate on the first day of the month following your death.

6. **Your Option to Terminate This Contract.** You may terminate this Contract at any time by giving us at least 30 days prior notice. If you terminate this Contract in this manner; we will prorate the premium and refund any portion of the premiums for the Contract which you have prepaid.

7. **Our Option to Terminate This Contract.** We may terminate this Contract for any of the following reasons:

   A. If we discontinue the entire class of contract to which this Contract belongs. In other words, we may terminate this Contract if we also terminate the same contract held by everyone else. We will give you at least 5 months written notice that this Contract will be terminated in this manner.

   B. If we discontinue all hospital, surgical or medical expense coverage in the individual direct payment market in this state, your coverage will terminate 180 days from the date we provide notice to you.

   C. We may terminate this Contract for any reason which is approved by the Superintendent of Insurance. If this Contract is terminated in this manner, a copy of the reason will be provided to you upon request. We will give you at least 30 days written notice that this Contract will be terminated in this manner.

   D. We may terminate this Contract if you committed fraud when you applied for this Contract or if you committed fraud when you filed any claim under this Contract.

   E. We may terminate this Contract if you do not provide documentation we request to certify or recertify that you meet the Child Health Plus eligibility requirements.

8. **Continued benefits after termination for total disability.** When your coverage under this contract ends, benefits stop. However, if you are, in our sole judgment, totally disabled on the date your coverage terminates, and you have received services or care for the illness, condition or injury which caused your total disability while you were covered under this Contract, we will continue to pay for your care directly related to the illness, condition or injury which caused your disability until the first of the following dates:

   A. A date you are, in our sole judgment, no longer totally disabled.

   B. A date twelve months from the date this Contract terminates, your coverage under this Contract terminates.

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

SECTION THIRTEEN — RIGHT TO NEW CONTRACT AFTER TERMINATION

If this Contract terminates under the circumstances described below, you may continue coverage by purchasing a new contract.

1. **If You Reach the Maximum Age for Coverage Under the Child Health Plus Program.** If this Contract terminates because you reach the maximum age for coverage under the Child Health Plus program you are entitled to purchase a new contract as a direct payment subscriber.

2. **Termination of the Child Health Plus Program.** If this Contract is terminated because the Child Health Plus program terminates or the State terminates this Contract, you are entitled to purchase a new contract as a direct payment subscriber.

3. **When to Apply for the New Contract.** If you are entitled to purchase a new contract, as described above, you must apply to us in writing for the new contract within 30 days after termination of this Contract or within 30 days after termination of your coverage under this Contract. You must also pay to us the first premium for the new contract within this same 30 day period.

4. **The New Contract.** The new contract will be our standard HMO contract issued upon conversion.

SECTION FOURTEEN — GENERAL PROVISIONS

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

2. **Notice.** Any notice, which we give to you under this Contract, will be mailed to your address as it appears on our records. If you have to give us any notice, it should be mailed to the address listed on the cover of this Contract.

3. **Your Medical Records.** In order to provide your coverage under this Contract, it may be necessary for us to obtain your medical records and information from Facilities or Professional Providers who treated you. Our actions to provide that coverage include processing your claims, reviewing grievances or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you become covered under this Contract, you automatically give us permission to obtain and use those records for those purposes.

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

4. **Time to File Claims.** Claims for services under this Contract must be submitted to us for payment within twenty-four months after you receive the services for which payment is being requested.

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

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

7. **Choice of Law.** This Contract shall be governed by the laws of the State of New York.

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

9. **Right to Offset.** If we make a claim payment to you or on your behalf in error or you owe us any money, you must repay the amount you owed to us. If we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we owe you.

10. **Continuation of Benefit Limitations.** Some of the benefits under this Contract are limited to a specific number of visits per Calendar Year. You will not be entitled to any additional benefits if your contract status should change during the Calendar Year. For example, if you convert from dependent to Subscriber, all benefits previously utilized during the Calendar Year will be applied toward your new contract status.

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

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

13. **Changes In This Contract.** We may unilaterally change this Contract upon giving you forty-four (44) days prior notice.

14. **Change in Status.** You and/or the responsible adult, as listed on the application, must report to us any change in status, such as residency, income or other insurance, that may make you ineligible for participation in Child Health Plus, within 60 days of such change. Failure to report such change within 60 days may result in a penalty in the amount of your Child Health Plus subsidy.

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

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

17. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards which describe in more detail when we will make or will not make payments under this Contract. Examples of the use of the standards are: to determine whether hospital inpatient care was Medically Necessary; whether emergency care in the outpatient department of a Hospital was necessary; or whether certain services are Skilled Care.

    Those standards will not be contrary to the descriptions in this Contract. If you have a question about the standards which apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Contract.

18. **Furnishing Information and Audit.** All persons covered under this Contract will promptly furnish us with all information and records, which we may require from time to time to perform our obligations under this Contract. You must provide us with information for reasons like the following: to allow us to determine the level of care you need; so that we may certify care authorized by your Primary Care Physician; or to make decisions regarding the Medical Necessity of your care.

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

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

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

    C. permit copying of the Member's records by us.

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

21. **Service Marks.** Excellus Health Plan, Inc., is an independent corporation organized under the Insurance Law of New York State. We also operate under licenses with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, which licenses us to use the Blue Cross and Blue Shield service marks in a portion of New York State. We do not act as an agent of the Blue Cross and Blue Shield Association. We are solely responsible for honoring our agreements to provide or administer benefits for health care.

22. **Grievance and Appeal.** Please refer to your Member Handbook for a description of our grievance and appeal procedures.

23. **Utilization Review.** Please refer to your Member Handbook for a description of our utilization review procedures.

24. **External Appeal.**

    A. **External Appeal in General.** You have the right to an "external appeal" of certain coverage determinations made by us. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent.

External Appeal Agents are certified by the State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal. "Requested service" or "requested services" refers to the service or services for which you are requesting coverage.

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

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

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

In general, you may not request an external appeal unless we have issued a "final adverse determination" of your request for coverage through the internal appeal process. Please see your Member Handbook for a description of our internal appeal process. You may ask us to agree to an external appeal even though you have not obtained a final adverse determination through the internal appeal process; however, we have no obligation to agree to your request.

If we do agree, we will send you a letter stating that we have agreed to an external appeal even though you have not obtained a final adverse determination.

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

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

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

Subparagraph G below provides information on requesting an external appeal.

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

In order to request an external appeal under this subparagraph, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one that, according to the current diagnosis of your attending physician, has a high probability of causing your death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

In addition, your attending physician must certify: that standard health services or procedures have been ineffective, or would be medically inappropriate in treating your life-threatening condition or disease; or, that no more beneficial standard treatment exists which is a covered service under this Contract.

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

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

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

In order to request an external appeal under this subparagraph, your attending physician must certify that you have a life-threatening or disabling condition or disease as described in subparagraph D above. In addition, your attending physician must certify that a clinical trial for your condition exists and that you are eligible to participate in the clinical trial.

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

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

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

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

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

- for services denied as not Medically Necessary, we will treat the service as Medically Necessary and provide coverage subject to all other conditions of this Contract.
- for services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of this Contract.
- for services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of this Contract. We are not required to pay for drugs or devices that are the subject of the clinical trial.

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

G. **Requesting an External Appeal.** If you meet the conditions described above, you may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your physician may file an appeal on your behalf. We will send a standard request form to you when we have made a final adverse determination. You or your physician may obtain additional standard request forms at any time from the State Insurance Department, the Department of Health, or by contacting us.

You must file your request for an external appeal with the State Insurance Department within 45 days of receiving a final adverse determination, or within 45 days of receiving a letter from us waiving the internal review process. We do not have the authority to grant extensions of this deadline.

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

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

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

BENEFIT EXPANSION RIDER TO
CHILD HEALTH PLUS CONTRACT

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This rider amends your subscriber contract by adding the following benefits:

Assertive Community Treatment Services. We will pay for Assertive Community Treatment Services (ACT), Young Adult ACT and Youth ACT. Services must be referred by a physician or other licensed provider of the healing arts, within their scope of practice under State law, for maximum reduction of physical or intellectual disability and restoration of a beneficiary to his best possible functional level.

Medical Supplies. We will pay for Medical Supplies which have been ordered by a provider in the treatment of a specific medical condition and which are usually consumable, nonreusable, disposable and for a specific purpose and generally have no salvageable value.

Orthodontic Services for a Severe Physically Handicapping Malocclusion. We will pay for orthodontic services for a severe physically handicapping malocclusion. Prior approval for orthodontia coverage is required. Services include orthodontic care for severe physically handicapping malocclusions as a once in a lifetime benefit that will be reimbursed for an eligible member for a maximum of three years of active orthodontic care, plus one year of retention care. Retreatment for relapsed cases is not a covered service. Treatment must be approved and active therapy begun (appliances placed and activated) prior to the member's 19th birthday.

Air Ambulance Services. We will pay for air ambulance services for catastrophic, life-threatening illnesses or conditions when; rapid transport is necessary to minimize risk of death or deterioration of the patient's condition; ground transport is not appropriate for the patient; or life-support equipment and advanced medical care is necessary during transport.

Transportation Between Facilities. We will pay for air and ground transportation between facilities when such services are considered emergency transports. This includes transport from an Emergency Room to a Psychiatric Center; transport from an Emergency Room to a Trauma/ Cardiac Care/Burn Center; transportation from an Emergency Room to an Emergency Room and transportation from an Emergency Room to Another Facility. Prior authorization is not required.

Children and Family Treatment and Support Services. We will pay for Children and Family Treatment and Support Services (CFTSS). Services may be delivered in the community where the child/youth lives, attends school and/or engages in services. Services include: Services provided by Other Licensed Professionals (OLP), Crisis Intervention, Community Psychiatric Supports and Treatment (CPST), Psychosocial Rehabilitation Services, Family Peer Support Services, Youth Peer Support.

Core Limited Health-Related Services. We will pay for Core Limited Health-Related Services at a Voluntary Foster Care Agency (VFCA) /29-I Health Facility. Health and behavioral health care services must meet reasonable and acceptable standards of health practice as determined by the State in consultation with recognized health organizations. Services include the following five Core Limited Health-Related Services: Skill building services; Nursing Services; Treatment Planning and Discharge Planning; Clinical Consultation/Supervision Services and VFCA Child Health Plus Liaison/Administrator.

All of the terms, conditions, and limitations of the Child Health Plus Contract to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.

EXCELLUS HEALTH PLAN, INC.
doing business as
Upstate HMO
165 Court Street
Rochester, NY 14647

By: 

James R. Reed
President and Chief Executive Officer
EXCELLUS HEALTH PLAN, INC.

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

BENEFIT EXPANSION RIDER TO
CHILD HEALTH PLUS CONTRACT

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

April 1, 2023

This rider amends your subscriber contract by adding the following benefit:

Residential Rehabilitation Services for Youth (RRSY). We will pay for Residential Rehabilitation Services for Youth (RRSY) provided by a program licensed, certified, or otherwise authorized by the Office of Addiction Services and Supports. Services must be clinically indicated and specified in the individualized treatment/recovery plan and/or progress notes.

All the terms, conditions, and limitations of the Child Health Plus Contract to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.

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MENTAL HEALTH AND CHEMICAL DEPENDENCE BENEFITS RIDER TO CHILD HEALTH PLUS CONTRACT

Issued by

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

This Rider changes the benefits for Mental Health and Chemical Dependence in your Child Health Plus Contract. All of the terms, conditions and limitations of the Contract to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

1. Paragraph 5 of Section Four, Inpatient Care, is deleted and replaced with the following:

   5. **Inpatient Mental Health Care, Inpatient Rehabilitation for Chemical Abuse and Inpatient Diagnosis and Treatment of Chemical Dependence (Detoxification).** We will provide coverage for hospitalization which, in the judgment of your Primary Care Physician and our Medical Director, is for mental health care, rehabilitation for chemical abuse or active treatment for detoxification needed because of chemical dependence. We will provide such coverage in a facility that is operating under Section 7.17 of the Mental Hygiene Law, Article 23 or 31 of the Mental Hygiene Law, or Article 28 of the Public Health Law.

2. Paragraph 7 of Section Five, Outpatient Care, is deleted and replaced with the following:

   7. **Mental Health and Chemical Dependence Visits.** We will provide coverage for mental health visits and chemical dependence visits for evaluation and treatment. Your provider must submit a Treatment Plan to us before we will approve services beyond initial consultation. Visits may be used for family therapy if related to the treatment of a family member's alcoholism or substance abuse.

      This service may be provided in a physician's office pursuant to Section Seven, Paragraph 13 or in the outpatient department of a hospital pursuant to this section.

3. Paragraph 13 of Section Seven, Professional Services, is deleted and replaced with the following:

   13. **Mental Health and Chemical Dependence Visits.** We will provide coverage for mental health visits and chemical dependence visits for evaluation and treatment or for the medical management of mental illness. Your provider must submit a Treatment Plan to us before we will approve services beyond the initial consultation.

      The services may be provided in the outpatient department of a hospital pursuant to Section Five, Paragraph 7, or in a doctor's office pursuant to this section.

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CHILD HEALTH PLUS RIDER FOR EXTERNAL APPEALS INVOLVING OUT-OF-NETWORK HEALTH SERVICES AND RARE DISEASES

Issued by

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

This Rider adds new requirements to the External Appeal provision in your Child Health Plus Contract. All of the terms, conditions and limitations of the Contract to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

The paragraph entitled "External Appeals" in the General Provisions Section of your Contract is hereby amended to add the following:

External Appeals Involving Out-of-Network Health Services. The following apply to external appeals involving out-of-network health services.

1. **Out-of-Network Defined.** An out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. You are not eligible for an external appeal if the service you request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating your condition.

2. **Certifying Physician.** The physician, who is your attending physician, must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition.

3. **Conditions for External Appeals Involving Out-of-Network Health Services.** In order to request an external appeal under this provision, the following conditions must be met:

   A. Coverage of a health service, for which benefits would otherwise be provided under your Contract, was denied, in whole or in part, on the grounds that the health service for which authorization was requested is out-of-network and an alternate recommended health service is available from a Participating Provider.

   B. We rendered a final adverse determination with respect to the out-of-network denial; or we agreed to an external appeal even though you did not obtain a final adverse determination.

   C. **Certification.** A physician, who meets the requirements in Paragraph 2 above, certifies that:

      (1) The out-of-network health service that you requested is materially different from the alternate service of a Participating Provider that we recommended.

(2) Based on two documents from the available medical and scientific evidence: the out-of-network service is likely to be more beneficial than the treatment available from a Participating Provider; and the adverse risk of the out-of-network service would not be substantially increased over the alternate service of a Participating Provider.

4. **Effect of External Appeal Agent's Decision; Coverage.** When the clinical peer reviewer determines that the out-of-network health service is not materially different from the alternate service available from a Participating Provider, we will not cover the out-of-network service.

When the clinical peer reviewer assigned by the external appeal agent determines that the out-of-network service is materially different from the alternate service available from a Participating Provider, the external appeal agent will assign a panel comprised of an odd number of clinical peer reviewers to determine whether we must cover the out-of-network service. We will provide coverage for the out-of-network service according to the terms, conditions and limitations of your Contract when a majority of the panel determines that the out-of-network service is likely to be more clinically beneficial than, and the adverse risk not substantially increased over, the alternate service available from a Participating Provider, and provides a written statement to that effect.

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

1. **Rare Disease Defined.** A life-threatening or disabling condition or disease that:

A. Is currently, or has been, subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or

B. Affects less than 200,000 United States residents per year; and

C. For which there does not exist a standard health service or procedure covered by your Contract that is more clinically beneficial than the requested health service or treatment.

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

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

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

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

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

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

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

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

4. **Effect of the External Appeal Agent's Decision; Coverage.** We will provide coverage for the requested health service or procedure according to the terms, conditions and limitations of your Contract when a majority of the panel of external appeal reviewers determines, based on the certification described in Subparagraph 3. A. above, and such other evidence as you, your designee or your attending physician may present, that the requested health service or procedure is likely to benefit you in the treatment of your Rare Disease, and that such benefit outweighs the risks of such health service or procedure.

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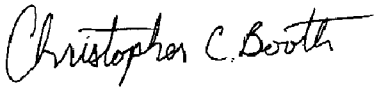
By: 

Christopher C. Booth
President and Chief Executive Officer

Excellus

Child Health Plus Rider for Autism Spectrum Disorder

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

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

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

2. Assistive Communication Devices. We will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we will provide coverage for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Our coverage is limited to dedicated devices; we will only cover devices that generally are not useful to a person in the absence of communication impairment. We will determine whether the device should be purchased or rented. We will not cover items, such as, but not limited to, laptops, desktops, or tablet computers. We will, however, cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered; however, we will cover one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member's current functional level. No coverage is provided for the additional cost of equipment or accessories that are not Medically Necessary. We will not provide coverage for delivery or service charges or for routine maintenance.

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

3. Behavioral health treatment. We will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed provider. We will provide coverage for applied behavior analysis when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst and who is subject to standards in regulations promulgated by the New York Department of Financial Services in consultation with the New York Departments of Health and Education. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant

improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

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

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

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

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

EXCELLUS HEALTH PLAN, INC.
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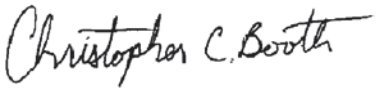
By: 

Christopher C. Booth
President and Chief Executive Officer

Excellus

OUTPATIENT BLOOD CLOTTING FACTOR BENEFIT RIDER TO CHILD HEALTH PLUS CONTRACT

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds certain benefits under Section Five — Outpatient Care in your Child Health Plus Contract. All of the terms, conditions and limitations of the Contract to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

SECTION FIVE — OUTPATIENT CARE

9. **Blood Clotting Factor.** We will pay for blood clotting factor products and other treatments and services furnished in connection with the care of hemophilia and other blood clotting protein deficiencies on an outpatient basis. We will pay for blood clotting factor products and services when infusion occurs in an outpatient setting or in the home by a home health care agency, a properly trained parent or legal guardian of a child, or a child that is physically and developmentally capable of self-administering such products.

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OSTOMY EQUIPMENT AND SUPPLIES BENEFIT RIDER TO CHILD HEALTH PLUS CONTRACT

Issued by

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

This Rider adds certain benefits for ostomy equipment and supplies under your Child Health Plus contract. All of the terms, conditions and limitations of the Child Health Plus contract to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

Ostomy Equipment and Supplies.
We will pay for ostomy equipment and supplies prescribed by a licensed health care provider legally authorized to prescribe under title eight of the Education Law.

EXCELLUS HEALTH PLAN, INC.
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PRESCRIPTION DRUG EXCLUSION RIDER TO CHILD HEALTH PLUS CONTRACT

Issued by

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

This Rider adds the following exclusion to Subparagraph 4.B in Section Eight of your Child Health Plus Contract:

16. Prescription drugs dispensed for the purpose of treating erectile dysfunction.

All of the terms, conditions and limitations of the Child Health Plus Contract to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.

EXCELLUS HEALTH PLAN, INC.
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PRESCRIPTION DRUG RIDER TO
CHILD HEALTH PLUS CONTRACT

Issued by

EXCELLUS HEALTH PLAN, INC.
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This Rider deletes Paragraph 4 of Section Eight of your Child Health Plus Contract and replaces it with the following:

4. Prescription Drugs. We will provide coverage for drugs, biologicals and compounded prescriptions that can be dispensed only pursuant to a prescription and that appear on our Drug Formulary. Our "Drug Formulary" is defined as a list of prescription drugs which are covered under this rider. This list is periodically reviewed and may be modified by us. No coverage is available for drugs not listed on our Drug Formulary or for a brand-name drug when the generic equivalent is medically appropriate. The drug must be prescribed by a Participating Provider, and approved by the FDA for the treatment of your specific diagnosis or condition. The drug must also be approved by us as Medically Necessary treatment of the condition for which the drug is prescribed. In certain situations, specific criteria including medical necessity criteria may be established by us and our provider community, defining whether certain drugs will be covered. However, if there is a drug that has been approved for the treatment of one type of cancer, we will also pay for this drug for the treatment of other types of cancer so long as the drug meets the requirements of Insurance Law Section 4303(q).

   For purposes of this Rider, Prescription Drugs shall also include non-prescription drugs which are authorized by a professional licensed to write prescriptions and which appear in the Medicaid drug formulary.

   Prescription Drugs shall also include Medically Necessary enteral formulas for which a Participating Provider has issued a written order. The written order must state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific method of treatment for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated. We will also pay for modified solid food products for the treatment of certain inherited diseases of amino acid or organic acid metabolism, when provided pursuant to such written order. However, our coverage for modified solid food products is limited to $2,500 per Calendar Year for such benefits.

   We will not pay any benefits under this Rider for Prescription Drugs you purchase at a non-participating pharmacy.

A. Limitations

1. We will periodically identify certain Prescription Drugs that, for reasons such as cost and possible use for purposes that are not Medically Necessary or appropriate, will only be filled with preauthorization from us. Our list of Prescription Drugs that require preauthorization is subject to periodic review and modification by our Pharmacy and Therapeutics Committee. Preauthorization may be obtained by calling the number on the Member's ID card. A denial of preauthorization or failure to obtain preauthorization will result in a denial of benefits for that prescription. Before having a prescription filled for the first time, you should contact us to inquire if a Prescription Drug requires preauthorization. You may do so by calling the number on your identification card.

2. We will pay for no more than a thirty (30) day supply of a drug purchased at a participating retail pharmacy. Benefits will be provided for drugs dispensed by a participating mail service pharmacy in a quantity of up to a ninety (90) day supply.

3. We reserve the right to limit quantities, day supply, early refill access and/or duration of therapy for certain medications based on acceptable medical standards and/or FDA recommended guidelines.

4. Benefits will be provided for drug refills. However, no benefit will be provided for a refill obtained before the date that you should have exhausted most of your current supply. Benefits for refills will not be provided beyond one year from the original prescription date.

5. A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.

6. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of medication. Such protocols shall be consistent with standard medical/drug treatment guidelines. The primary goal of such program is to provide our members a quality-focused drug benefit. In the event a use management protocol is implemented, you will be notified in advance.

B. Exclusions

1. Drugs that do not by law require a prescription, except as otherwise provided in this Rider.

2. Prescription Drugs that have over the counter non-prescription equivalents, except as otherwise provided under this Rider. Non-prescription equivalents are drugs available without a prescription that contain the same active ingredient as their prescription counterparts.

3. Devices of any type, even though a prescription may be required. This includes therapeutic devices, artificial appliances or similar devices. We will, however, provide coverage for contraceptive devices, including basal thermometers, male and female condoms and diaphragms.

4. Vitamins, or any herbal products, except those that require a prescription by law.

5. Drugs that are prescribed or dispensed for cosmetic purposes, such as hair growth or removing wrinkles.

6. Drugs prescribed or dispensed in anticipation of or in connection with transsexual surgery.

7. Drugs that we determine are prescribed for experimental or investigational use; or that are only available to Members who participate in clinical research programs, unless otherwise required to be covered by external review.

8. Drugs for which payment is available under a workers' compensation law or similar legislation. We will not make any payment under the Rider even if you do not receive workers' compensation benefits because a proper or timely claim for benefits under the law was not submitted or you fail to appear at a workers' compensation hearing.

9. Drugs for which payment is covered by mandatory automobile "no-fault" benefits.

10. Drugs or other pharmacy services provided to you pursuant to a referral prohibited by Section 238-a of the New York Public Health Law. (Generally, Section 238-a prohibits providers from making referrals for pharmacy or other services to a provider, pharmacy or facility in which the referring provider or an immediate family member has a financial interest or relationship.)

11. Prescription Drugs to replace those that may have been lost or stolen.

12. Drugs dispensed in unit-dose packaging when bulk packaging is available

13. Drugs given or administered in a physician's office or in an inpatient or outpatient facility.

14. Administration or injection of any drugs.

15. Drugs dispensed to a Member while a patient in a hospital, nursing home, other institution, or a patient of a home care services agency, except in those cases where the basis of payment by or on behalf of the member to the hospital, nursing home, home care services agency, or other institution does not include services for drugs.

16. Prescription drugs dispensed for the purpose of treating erectile dysfunction.

C. General Conditions

1. You must present your identification card to a retail pharmacy and include your identification number on the forms provided by the participating mail order pharmacy from which you make a purchase.

2. As a condition precedent to the approval of claims hereunder, each Member authorizes and directs any Participating Pharmacy which furnished benefits hereunder to make available to us information relating to all prescription orders, copies thereof and other records as needed by us for purposes of administering this Rider. We shall in every case hold such information and records as confidential.

3. We conduct various utilization management activities designed to ensure appropriate prescription drug usage, to avoid inappropriate usage and to encourage the use of cost effective drugs. Through these efforts, you benefit by obtaining appropriate prescription drugs in a cost effective manner. The cost savings resulting from these activities are reflected in the premiums for your coverage. We may, from time to time, also enter into agreements that result in us receiving rebates or other funds ("rebates") directly or indirectly from prescription drug manufacturers, prescription drug distributors or others. Any rebates are based upon utilization of prescription drug products across all of our business and not solely on any one member's or one group's utilization of prescription drugs. Any rebates received by us may or may not be applied, in whole or in part, to reduce premiums either through an adjustment or claims costs or as an adjustment to the administrative expenses component of our prescription drug premiums.

   Any such rebates may instead be retained by us, at our discretion, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of subscribers.

4. We shall not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of merchantability), arising out of or in connections with the sale, compounding, dispensing, manufacturing or use of any Prescription Drug whether or not covered under this Rider.

5. We reserve the right to deny benefits for any drug prescribed or dispensed in a manner contrary to normal medical practice.

All of the terms, conditions and limitations of the Child Health Plus Contract to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.

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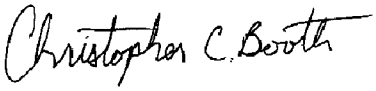
By: 

Christopher C. Booth
President and Chief Executive Officer

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PRESCRIPTION DRUGS REQUIRING PRIOR AUTHORIZATION

Issued by

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

The prior authorization requirements described below apply to the prescription drug benefit in the Rider to your Contract; this form is considered to be attached to, and a part of, the Rider. All of the terms, conditions and limitations of the Rider to which this form applies also apply to this form.

1. **FDA-Approved Prescription Drugs.** The following Prescription Drugs require prior authorization:

Drug Class	**Prescription Drug**
BLOOD DISORDERS	Aranesp, Epogen, Procrit
CANCER	Nexavar, Revlimid, Sprycel, Sutent, Tarceva, Zolinza
CARDIOVASCULAR/HEART: Calcium Channel Blockers	 Norvasc
CENTRAL NERVOUS SYSTEM:	Provigil
CYSTIC FIBROSIS:	Pulmozyme, TOBI
DERMATOLOGY: Psoriasis	Enbrel, Raptiva
ENTERAL FORMULAS:	All Enteral Formulas
GROWTH HORMONE:	All Growth Hormones
HEPATITIS B:	All Hepatitis B medications
HEPATITIS C:	All Hepatitis C medications
INFECTIONS: Antibiotics Antifungals	 Zyvox itraconazole, Lamisil
MENTAL HEALTH	Emsam
NITRATES	Ranexa
OSTEOPOROSIS:	Forteo
PULMONARY ARTERIAL HYPERTENSION:	 Revatio, Tracleer
RHEUMATOID ARTHRITIS:	Enbrel, Humira, Kineret
STOMACH: Irritable Bowel Syndrome	Amitiza, Zelnorm
WEIGHT MANAGEMENT:	Meridia, Xenical
MISCELLANEOUS:	Lupron, Zoladex: when used for endometriosis, myoma, precocious puberty, prostate cancer Actimmune, Caduet, Daytrana, Exubera, Fentora, Inspra, Relenza, Solodyn, Somavert, Tamiflu, Xyrem, Zavesca

2. **Recently Approved Prescription Drugs; Drugs Expected To Receive FDA Approval.** The following drugs that recently received FDA approval, or are expected to receive FDA approval during 2007 or early 2008, require prior authorization:

Drug Class	**Prescription Drug**
ANEMIA:	C.E.R.A.*
CANCER:	Fibrillex* (eprodisate), satraplatin*, Tasigna* (nilotinib), Torisel* (temsirolimus), Tykerb* (lapatinib), vatalanib*
CENTRAL NERVOUS SYSTEM:	Nuvigil* (armodafanil)
GASTROINTESTINAL:	Cimzia* (certolizumab)
HEPATITIS C	viramidine*
LUPUS:	Riquent* (abetimus)
OBESITY, WEIGHT LOSS:	Accomplia* (rimonabant) , Axokine*
PULMONARY ARTERIAL HYPERTENSION:	ambrisentan*, Thelin* (sitaxsentan)
SEXUAL DYSFUNCTION:	dapoxetine*
MISCELLANEOUS	Icatibant*, glutamine*

* Pending FDA approval / release

3. **Other Drugs That Receive FDA Approval.** Prior authorization applies to all new drugs entering the market upon FDA approval, whether or not listed in Paragraph 2 above, until we determine that the new drug satisfies our criteria for safety and efficacy.

4. **Step Therapy Program.** The following Prescription Drugs require prior authorization if a Generic Drug or cost-effective alternative Prescription Drug has not been tried:

Drug Class	**Prescription Drug**
ALLERGY: Antihistamines	Zyrtec
CARDIOVASCULAR/HEART:	
Antihyperlipidemics	Lipitor, Vytorin
Angiotensin Receptor Blockers/ Combinations	Avapro, Avalide, Diovan, Diovan HCT
DERMATOLOGY:	
Topical/Oral Steroids	Clobex Spray
DIABETES:	
Blood Glucose Supplies	All non-preferred meters and/or strips (Preferred meters/strips: any **Accu-check** or **One Touch** product)
Injectables:	Byetta, Galvus*, Janjuvia*, Pargluva*, Symlin
MEN'S HEALTH: BPH Agnets (Prostate)	Flomax, Uroxatrol
MENTAL HEALTH: Antidepressants	Cymbalta, Effexor XR
PAIN: Cox2 Inhibitors / NSAIDs	Celebrex, Branded NSAIDs: Arthrotec, Cataflam, Daypro, EC-Naprosyn, Lodine XL, Mobic, Naprelan, Oruvail, Ponstel, Relafen, Toradol, Voltaren XR
PARKINSON'S:	Azilect
STOMACH: Heartburn/Proton Pump Inhibitors	omeprazole, Prevacid, Protonix

* Pending FDA approval

New Brand Name Drugs in the drug classes listed above in Paragraph 4 will be subject to prior authorization under the step therapy requirement.

5. **Prescription Drugs Added To The Step Therapy Program During 2007.** The Prescription Drugs listed below will be added to the Step Therapy Program during 2007. The drugs require prior authorization if a Generic Drug or other cost-effective alternative has not been tried:

Drug Class	**Prescription Drug**
ANTISPASMODIC	All antispasmodics
ASTHMA: Leukotriene Inhibitors:	All Leukotriene Inhibitors
ATTENTION DEFICIT DISORDER	All Attention Deficit Disorder medications
DIABETIC: Insulin	Humulin, Humalog
MENTAL HEALTH	All antipsychotics, anticonvulsants, and sedatives/hypnotics
PAIN RELIEVERS: Narcotic	fentanyl (all dosage forms), Oxycontin (oxycodone SR)
SMOKING DETERRENTS	Chantix

EXCELLUS HEALTH PLAN, INC.
doing business as

Upstate HMO
165 Court Street
Rochester, NY 14647

By: Christopher C. Booth

Christopher C. Booth
President and Chief Executive Officer

Excellus

LIST OF SPECIALTY MEDICATIONS

Issued by

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

This List applies to your Endorsement for Specialty Medication Pharmacy Network; it is considered to be attached to, and a part of, the Endorsement. All of the terms, conditions and limitations of the Rider or Endorsement to which this List applies also apply to this List.

Used in the Treatment of:	Specialty Medication
Blood Cell Modification	Neumega
Crohn's Disease	Cimzia*
Cystic Fibrosis	Pulmozyme, TOBI
Growth Hormone	All Growth Hormone
Hepatitis C	All Hepatitis C
Multiple Sclerosis	All Multiple Sclerosis
Lupus	Riquent*
Osteoporosis	Forte
Psoriasis	Enbrel, Raptiva
Pulmonary Arterial Hypertension	ambrisentan*, Thelin*
Rheumatoid Arthritis	Cimzia*, Enbrel, Humira, Kineret

* Pending FDA approval. Upon approval (unless the approval is for exclusive distribution by a pharmacy not in our Specialty Network), the medication will be subject to the requirements of your Rider or Endorsement for Specialty Medication Pharmacy Network.

Other Specialty Medications That Receive FDA Approval. You must use the Specialty Pharmacy Network for all new Specialty Medications entering the market upon FDA approval. Specialty Medications are generally injectable, but can be oral, topical or inhaled, Prescription Drugs that require special handling and close supervision and monitoring of the patient's drug therapy.

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ENDORSEMENT FOR SPECIALTY MEDICATION PHARMACY NETWORK

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Endorsement changes certain benefits for prescription drugs under your Prescription Drug Rider. All of the terms, conditions and limitations of the Rider to which this Endorsement is attached also apply to this Endorsement, except where they are specifically changed by this Endorsement.

1. **Definitions.**

   A. **Specialty Medications.** Prescription Drugs covered under your Prescription Drug Rider that are used to treat conditions such as multiple sclerosis, hepatitis C, rheumatoid arthritis, infertility and growth hormone deficiency; and included on the form entitled "List of Specialty Medications" that applies to this Endorsement. Most Specialty Medications are injectables. However, our list also includes select oral medications, compound medications and other types of covered Prescription Drugs.

   Our List of Specialty Medications may be revised from time-to-time based on the introduction of new drugs and/or new clinical information, and after review by our Pharmacy and Therapeutics Committee. If our records show that you are taking a Prescription Drug that will be added to the List of Specialty Medications, we will notify you in writing at least 30 days in advance of the addition of the drug to the list. A current List of Specialty Medications can be obtained by writing or calling our office and is available on our website at the address in Subparagraph B below.

   B. **Specialty Pharmacy Network.** Retail and specialty pharmacies that have agreements with us to dispense Specialty Medications to our Members. We have a list of the pharmacies that participate in the Specialty Pharmacy Network. You will receive a copy of the list with this Endorsement and may request a copy in writing or by telephone, or you may view a copy of the list on our website at www.excellusbcbs.com.

2. **You Must Obtain Specialty Medications Through The Specialty Pharmacy Network.** In order to receive coverage for a Specialty Medication under your Prescription Drug Rider, you must obtain the drug from a Specialty Pharmacy Network pharmacy. If you do not comply with this requirement, you must pay the full cost of the Specialty Medication. As described in Paragraph 3 below, the initial fill of a Specialty Medication is the only exception.

3. **Initial Fill Exception.** The requirements of this Endorsement will not apply to the initial fill of a Specialty Medication. We will provide coverage for the initial fill of a Specialty Medication as set forth in your Prescription Drug Rider. Thereafter, you must obtain the Specialty Medication through the Specialty Pharmacy Network.

4. **Days' Supply.** We will provide benefits for Specialty Medications in a quantity of up to the days' supply limit that, according to your Prescription Drug Rider, or any Endorsement thereto, applies to Prescription Drugs dispensed by a retail pharmacy.

EXCELLUS HEALTH PLAN, INC.
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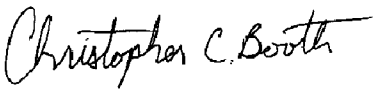
By: 

Christopher C. Booth
President and Chief Executive Officer

Excellus

CHILD HEALTH PLUS DENTAL RIDER

Issued by

EXCELLUS HEALTH PLAN, INC.

A nonprofit independent licensee of the BlueCross BlueShield Association

This Rider adds dental benefits to your Child Health Plus contract. We will pay for the dental services listed below when they are provided by a Participating Provider:

1. **Emergency Dental Care.** We will pay for emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

2. **Preventive Dental Services.** We will pay for the preventive dental services listed below:

   A. Dental Prophylaxis. Benefits for dental prophylaxis, including scaling and polishing teeth, will be provided once per six-month period.

   B. Topical Fluoride Treatments. Benefits will be provided once per six-month period where local water supply is not fluoridated.

   C. Topical Application of Sealants. We will provide sealants on unrestored first and second permanent molar teeth for children between the ages of 5 and 15.

3. **Routine Dental Care.** We will pay for the routine dental services listed below:

   A. Dental Examinations. We will pay for dental examinations, visits and consultations once per six-month period once primary teeth erupt.

   B. Radiographs. We will pay for full mouth or panoramic x-rays once every thirty-six months if necessary; bitewing x-rays once per calendar year; and other diagnostic x-rays as required (once primary teeth erupt).

   C. All necessary procedures for simple extractions and other routine dental surgery, including:

      - simple removal of erupted deciduous and permanent teeth
      - surgical removal of erupted teeth
      - removal of exposed roots
      - surgical removal of residual tooth roots (unexposed)
      - removal of supernumerary teeth
      - surgical exposure of unerupted teeth
      - simple biopsy of hard/soft tissue
      - alveoplasty - surgical preparation of mouth for prosthetic placement

- excision of benign lesions
- incision and drainage of abscess
- frenectomy or frenotomy
- removal of third molars, impacted - soft tissue; partial bony; full bony

D. Amalgam, anterior composite restorations and coverage of prefabricated resin crowns and prefabricated stainless steel crowns with resin windows.

4. **Endodontics.** We will pay for endodontic services, including all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.

5. **Periodontics.** We will pay for periodontic services, subject to dental review and guidelines, including:
   - periodontic services consisting of gingivectomy or gingivoplasty per quadrant specifically for acute or severe hyperplasia or hypertrophy associated with drug therapy, hormonal distrubances or congenital defects.
   - treatment for necrotizing ulcerative gingivitis, including debridement and medication

We will not pay for periodontic services in anticipation of, or leading to, orthodontia.

6. **Prosthodontics.** We will pay for prosthodontic services as follows:

   A. Removable complete or partial dentures, including six (6) months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases. Fixed bridges are not covered unless (1) they are required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full compliment of natural, functional and/or restored teeth; (2) for cleft-palate stabilization; or (3) due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

   B. Unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

All of the terms, conditions and limitations of your Child Health Plus contract to which this Rider attaches also apply to this Rider, except where specifically changed by this Rider.

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Patient Self Determination Policy

Advance Directives

Do Not Resuscitate Orders
Health-Care Proxies (Proxy enclosed)
Living Wills

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Pursuant to the Federal Patient Self-Determination Act of 1990 and the New York State Health Department Regulations, we must provide our members with certain information regarding their rights under New York Law to:

(1) make medical care decisions,

(2) accept or refuse medical treatment; including the right to refuse life-sustaining medical and surgical treatment, and

(3) make advance directives about their medical care in the event they lack capacity to make such decisions.

This policy is one of the documents we must distribute to members upon enrollment.

1. **Informed Consent.**

Any competent adult (which includes a person who is under 18 years of age and who is either married or has a child) has the right to accept, decline, terminate or withdraw medical treatment, even life-saving and life-sustaining treatment, and can refuse nutrition and hydration. In addition, pregnant minors have the right to consent to treatment relating to their pregnancy and a parent's consent is not required when emergency treatment involves a minor.

A member is entitled to be advised of an existing medical condition, the prognosis of the medical condition, the possible treatments which are professionally sound for the medical condition, and the probable benefits and risks associated with each treatment before the member makes a decision regarding medical care. This is known as the "informed consent" rule.

A member cannot require us or our physicians or other health-care providers to provide treatment which is not professionally sound or would be medically futile for the medical condition in question.

2. **Advance Directives.**

New York Law allows the following types of advance directives:

1. Consents to Orders Not to Resuscitate, commonly known as "Do Not Resuscitate Orders" ("DNR Orders")
2. Health-Care Proxies
3. Living Wills

The law and our policy on these advance directives is described below.

3. **Consents to DNR Orders.**

A DNR Order is an order issued by the member's attending physician which permits the health-care provider not to administer cardiopulmonary resuscitation (CPR), in the event of a cardiac or respiratory arrest. CPR is a medical procedure administered to restore cardiac function or to support ventilation in the event of cardiac or respiratory arrest.

If a member does not consent to the issuance of a DNR Order, it will be presumed that the member has consented to CPR in the event of cardiac or respiratory arrest.

A member can give consent to the issuance of a DNR Order either orally or in writing. If the consent is oral, it can only be made in a hospital (not in an HMO facility and not in a physician's office). An oral consent must be clearly stated before two witnesses who are at least 18 years of age, one of whom must be a physician affiliated with the hospital. The substance of the oral consent must be entered in the member's hospital medical record.

Written consent to the issuance of a DNR Order can be made in any form and must be witnessed by two persons who are at least 18 years of age, and who must also sign the consent. Written consent can be made in any HMO facility or physician's office.

A member who gives written consent to the issuance of a DNR Order should supply the HMO physician with a copy of the consent so that it can be entered in the member's medical records. However, a written consent is only effective when the member is a patient in a hospital or residential care facility. It is not effective while a member is being treated in an HMO facility or physician's office.

The consent will be followed by the HMO and its physicians only if the member is hospitalized and lacks capacity to make medical decisions, which will be determined by the member's attending physician.

A member's written or oral consent to the issuance of a DNR Order can be terminated at any time. The termination can be in writing (which does not have to be witnessed), or by oral declaration to an HMO employee or to a physician (the termination should be noted in the primary care physician's medical record). No special language is needed, so long as the member expresses an intent to terminate consent. Termination can even be accomplished by a body message, such as a nod of the head, if the member cannot talk or write.

If a member has not consented to a DNR Order, such consent can be made by the member's surrogate, provided the member lacks capacity to make medical-care decisions, but only in certain limited situations which are discussed below.

The Surrogate is the first of the following persons who exists, and is able and willing to make a decision:

- the court-appointed committee of the member,
- the member's spouse,
- a member's son or daughter who is 18 years of age or older,
- a member's parent,
- a member's brother or sister who is 18 years of age or older,
- a close friend of the member.

A Surrogate can only consent to the issuance of a DNR Order if the member's attending physician, after a personal examination of the member, determines (with a reasonable degree of medical certainty) that:

- the member has a terminal condition; or
- the member is permanently unconscious; or
- resuscitation would be medically futile; or
- resuscitation would impose an extraordinary burden on the member in light of the member's medical condition and the expected outcome of resuscitation.

The attending physician's determination must be supported by a second opinion.

4. **Health-Care Proxies.**

Under New York State law, any competent member has the power to appoint another adult (and an alternate adult) to act as their health-care agent. The appointment is made by executing a health-care proxy. A health-care proxy must be in writing, signed and dated by the member before two witnesses, who must also sign the proxy.

Any adult person can be appointed as a health-care agent, except: a non-relative employee of a hospital and any non-relative employee of the HMO. It is suggested that members refrain from appointing HMO physicians as health-care agents, since the physician will not be able to subsequently act as the member's physician.

The health-care proxy form published by the New York State Department of Health should be utilized for all health-care proxies, since this form will be generally accepted by all hospitals, residential health-care facilities and other health-care providers, and will be familiar to the HMO's physicians and staff. This form is included in the New York State Department of Health's publication entitled "Appointing Your Health-Care Agent - New York State's Proxy Law."

The HMO or the primary care physician will supply the New York State Department of Health's health-care proxy when requested.

The health-care proxy can specify a date, event or condition when it shall terminate, can state the member's wishes or instructions about health-care decisions and can contain conditions and limitations on the health-care agent's power to make medical-care decisions. For example, a member can:

- limit the duration of the health-care proxy.
- limit its use to only certain conditions, such as an impending surgery and recovery.
- specify that CPR is not to be administered.
- prohibit or insist on certain medical or surgical procedures.

While the member has capacity, the member has full and complete power to make their own health-care decisions, and the health-care proxy document is ineffective. If the member lacks capacity, as determined by the member's attending physician, the agent has full and complete power to make medical-care decisions for the member unless limitations are included in the health-care proxy. The agent has the right to receive all medical information pertaining to the member and be given medical advice with respect to the member to the same extent the member would have a right to receive such information or advice.

In the event that a medical-care decision is made by the agent to withdraw or withhold life sustaining treatment, the attending physician must obtain a second medical opinion to confirm the initial opinion of the member's lack of capacity.

Each member who signs a health-care proxy is urged to make their decision and wishes with respect to future medical care known to the agent. Each member should discuss these matters with the agent.

If the member's wishes are not known, the health-care decisions can be made by the agent in accordance with the member's best interests. The member's religious and moral beliefs may be considered. Agents cannot make decisions regarding the administration of artificial nutrition and hydration, unless the member's wishes are known or can be reasonably ascertained.

The health-care proxy can be revoked by the member at any time. Revocation can be either oral or written and should be immediately entered in the member's medical records as soon as the revocation becomes known to the HMO or physician.

Our physicians and providers will honor any health-care decision properly made by an agent pursuant to a properly-signed and witnessed health-care proxy, if the attending physician determines that the member lacks capacity to make medical care decisions.

5. **Non-Statutory Advance Directives (i.e., Living Wills).**

DNR orders and health-care proxies are the only advance directives recognized by statute in New York State. However, courts have recognized and upheld the use of other written documents (commonly called "living wills"), if there is "clear and convincing" evidence of a patient's desire to withhold or withdraw certain medical treatments when the patient lacks capacity to make medical-care decisions.

Under the court cases, the living will has to be created and signed by the member while the member has capacity to make medical decisions. The usual living will in New York State is a written statement that "no heroic measures or extraordinary treatment" be provided if the member is incapacitated.

Since New York does not have a living will statute, it is our policy to require a court order finding "clear and convincing" evidence of a patient's desire to withhold or withdraw medical treatments before we will honor instructions made in a living will.

Any member who desires a living will should consult their attorney.

6. **Member's Free Choice Whether to Utilize an Advance Directive.**

We do not encourage or discourage members to make any type of advance directive.

Our physicians and all staff are reminded that a member cannot be required to make an advance directive.

We will not discriminate against any member in the providing of medical care based on whatever a member has executed as an advance directive.

Each physician or other provider is encouraged to answer any questions regarding a member's rights to make medical-care decisions and to make advance directives.

7. **Documents to Be Distributed Upon Enrollment.**

We will provide copies of this policy as well as the New York State Health Department documents entitled: "Planning in Advance for your Medical Treatment," "Do Not Resuscitate Order - A Guide for Patients and Families," and "Appointing Your Health-Care Agent - New York States Proxy Law," to each person upon enrollment. All documents are contained in this booklet.

8. **Medical Record Notations.**

Each physician or other provider who first treats a member after adoption of this policy will inquire whether the member has an advance directive and will note the response in the member's medical record.

All physicians and other employees are required to immediately enter into a member's medical records, any advance directive or any revocation of an advance directive, which comes to their attention.

(NOTE: In an IPA model HMO, the member's medical record is the medical record maintained by the member's primary care physician).

9. Education of Staff and Community.

We will educate our staff and providers concerning our policies and procedures concerning advance directives.

We will provide education to the community on issues concerning advance directives.

PLANNING IN ADVANCE
FOR
YOUR MEDICAL TREATMENT

Your Right to Decide About Treatment

Adults in New York State have the right to accept or refuse medical treatment, including life-sustaining treatment. Our Constitution and state laws protect this right. This means that you have the right to request or consent to treatment, to refuse treatment before it has started, and to have treatment stopped once it has begun.

Planning in Advance

Sometimes because of illness or injury, people are unable to talk to a doctor and decide about treatment for themselves. You may wish to plan in advance to make sure that your wishes about treatment will be followed if you become unable to decide for yourself for a short or long time period. If you don't plan ahead, family members or other people close to you may not be allowed to make decisions for you and follow your wishes.

In New York State, appointing someone you can trust to decide about treatment if you become unable to decide for yourself is the best way to protect your treatment wishes and concerns. You have the right to appoint someone by filling out a form called a Health Care Proxy. A copy of the form and information about the Health Care Proxy are available in this booklet and from your health care provider.

If you have no one you can appoint to decide for you, or do not want to appoint someone, you can also give specific instructions about treatment in advance. Those instructions can be written, and are often referred to as a Living Will.

You should understand that general instructions about refusing treatment, even if written down, may not be effective. Your instructions must clearly cover the treatment decisions that must be made. For example, if you just write down that you do not want "heroic measures," the instructions may not be specific enough. You should say the kind of treatment that you do not want, such as a respirator or chemotherapy, and describe the medical condition when you would refuse the treatment, such as when you are terminally ill or permanently unconscious with no hope of recovering. You can also give instructions orally by discussing your treatment wishes with your doctor, family members or others close to you.

Putting things in writing is safer than simply speaking to people, but neither method is as effective as appointing someone to decide for you. It is often hard for people to know in advance what will happen to them or what their medical needs will be in the future. If you choose someone to make decisions for you, that person can talk to your doctor and make decisions that they believe you would have wanted or that are best for you when needed. If you appoint someone and also leave instructions about treatment in a Living Will, in the space provided on the Health Care Proxy form itself, or in some other manner, the person you select can use these instructions as guidance to make the right decision for you.

Deciding About Cardiopulmonary Resuscitation

Your right to decide about treatment also includes the right to decide about cardiopulmonary resuscitation (CPR). CPR is emergency treatment to restart the heart and lungs when your breathing or circulation stops.

Sometimes doctors and patients decide in advance that CPR should not be provided, and the doctor gives the medical staff an order not to resuscitate (DNR order). If your physical or mental condition prevents you from deciding about CPR, someone you appoint, your family members, or others close to you can decide.

New York State Department of Health 12/91

Deciding about CPR:
Do-Not-Resuscitate Orders (DNR)

What do CPR and DNR order mean?

CPR - cardiopulmonary resuscitation - refers to the medical procedures used to restart a patient's heart and breathing when the patient suffers heart failure. CPR may involve simple efforts such as mount-to-mouth resuscitation and external chest compression. Advanced CPR may involve electric shock, insertion of a tube to open the patient's airway, injection of medication into the heart and, in extreme cases, open chest heart massage.

A do-not-resuscitate (DNR) order tells medical professionals not to perform CPR. This means that doctors, nurses and emergency medical personnel will not attempt emergency CPR if the patient's breathing or heartbeat stops.

DNR orders may be written for patients in a hospital or nursing home, or for patients at home. Hospital DNR orders tell the medical staff not to revive the patient if cardiac arrest occurs. If the patient is in a nursing home or at home, a DNR order tells the staff and emergency medical personnel not to perform emergency resuscitation and not to transfer the patient to a hospital for CPR.

Why are DNR orders issued?

CPR, when successful, restores heartbeat and breathing and allows patients to resume their previous lifestyle. The success of CPR depends on the patient's overall medical condition. Age alone does not determine whether CPR will be successful, although illnesses and frailties that go along with age often make CPR less successful.

When patients are seriously ill or terminally ill, CPR may not work or may only partially work, leaving the patient brain-damaged or in a worse medical state than before the heart stopped. In these cases, some patients prefer to be cared for without aggressive efforts at resuscitation upon their death.

Can I request a DNR order?

Yes. All adult patients can request a DNR order. If you are sick and unable to tell your doctor that you want a DNR order written, a family member or close friend can decide for you.

Is my right to request or receive other treatment affected by a DNR order?

No. A DNR order is only a decision about CPR and does not relate to any other treatment.

Are DNR orders ethically acceptable?

It is widely recognized by health care professionals, clergy, lawyers and others that DNR orders are medically and ethically appropriate under certain circumstances. For some patients, CPR offers more burdens than benefits, and may be against the patient's wishes.

Is my consent required for a DNR order?

Your doctor must speak to you before entering a DNR order if you are able to decide, unless your doctor believes that discussing CPR with you would cause you severe harm. In an emergency, it is assumed that all patients would consent to CPR. However, if a doctor decides that CPR will not work, it is not provided.

How can I make my wishes about DNR known?

An adult patient may consent to a DNR order orally by informing a physician, or in writing, such as a living will, if two witnesses are present. In addition, the Health Care Proxy Law allows you to appoint someone you trust to make decisions about CPR and other treatments if you become unable to decide for yourself.

Before deciding about CPR, you should speak with your doctor about your overall health and the benefits and burdens CPR would provide for you. A full and early discussion between you and your doctor will assure that your wishes will be known.

If I request a DNR order, must my doctor honor my wishes?

If you don't want CPR and you request a DNR order, your doctor must follow your wishes or:

- transfer your care to another doctor who will follow your wishes; or
- begin a process to settle the dispute if you are in a hospital or nursing home.

If the dispute is not resolved within 72 hours, your doctor must enter the order or transfer you to the care of another doctor.

Appointing Your Health Care Agent
NEW YORK STATE'S PROXY LAW

A new law called the New York health care proxy law allows you to appoint someone you trust -- for example, a family member or close friend -- to decide about treatment if you lose the ability to decide for yourself. You can do this by using a Health Care Proxy form like the one on the back of this booklet, to appoint your "health care agent."

The law gives you the power to make sure that health care professionals follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own.

You can give the person you select, your health care agent, as little or as much authority as you want. You can allow your agent to decide about all health care or only certain treatments. You may also give your agent instructions that he or she has to follow.

Why should I choose a health care agent?

If you become too sick to make health care decisions, someone else must decide for you. Health care professionals often look to family members for guidance. But family members are not allowed to decide to stop treatment, even when they believe that is what you would choose or what is best for you under the circumstances. Appointing an agent lets you control your medical treatment by:

- allowing your agent to stop treatment when he or she decides that it is what you would want or what is best for you under the circumstances;
- choosing one family member to decide about treatment because you think that person would make the best decisions or because you want to avoid conflict or confusion about who should decide; and
- choosing someone outside your family to decide about treatment because no one in your family is available or because you prefer that someone other than a family member decide about your health care.

How can I appoint a health care agent?

All competent adults can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer, just two adult witnesses. You can use the form printed in the center of this booklet, but you don't have to.

When would my health care agent begin to make treatment decisions for me?

Your health care agent would begin to make treatment decisions after doctors decide that you are not able to make health care decisions. As long as you are able to make treatment decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any treatment decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accord with your wishes and interests.

If your health care agent is not aware of your wishes about artificial nutrition and hydration (nourishment and water provided by feeding tubes), he or she will not be able to make decisions about these measures. Artificial nutrition and hydration are used in many circumstances, and are often used to continue the life of patients who are in a permanent coma.

How will my health care agent make decisions?

You can write instructions on the proxy form. Your agent must follow your oral and written instructions, as well as your moral and religious beliefs. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interests.

Who will pay attention to my agent?

All hospitals, doctors and other health care facilities are legally required to honor the decisions by your agent. If a hospital objects to some treatment options (such as removing certain treatment) they must tell you or your agent **IN ADVANCE.**

What if my health care agent is not available when decisions must be made?

You can appoint an alternate agent to decide for you if your health care agent is not available or able to act when decisions must be made. Otherwise, health care providers will make treatment decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel the proxy, to change the person you have chosen as your health care agent or to change any treatment instructions you have written on your Health Care Proxy form. Just fill out a new form. In addition, you can require that the Health Care Proxy expire on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent and you get divorced or legally separated, the appointment is automatically cancelled.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for treatment decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Is a health care proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care treatment. It is generally used to declare wishes to refuse life-sustaining treatment under certain circumstances.

In contrast, the health care proxy allows you to choose someone you trust to make treatment decisions on your behalf. Unlike a living will, a health care proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made. The health care proxy is just as useful for decisions to receive treatment as it is for decisions to stop treatment. If you complete a Health Care Proxy form, but also have a living will, the living will provides instructions for your health care agent, and will guide his or her decisions.

Where should I keep the proxy form after it is signed?

Give a copy to your agent, your doctor and any other family members or close friends you want. You can also keep a copy in your wallet or purse or with other important papers.

Appointing a Health Care Agent is a serious decision. Make sure you talk about it with your family, close friends and your doctor.

Do it in advance, not just when you are planning to enter the hospital.

Filling out a health care proxy is voluntary. No one can require to you to do so.

The Health Care Proxy Law takes effect January 1991; forms signed before that date are valid.

About the Health Care Proxy

This is an important legal form. Before signing this form, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or provide life-sustaining treatment.
3. Unless your agent knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse or consent to those measures for you.
4. Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

If I become terminally ill, I do/don't want to receive the following treatments....

If I am in a coma or unconscious, with no hope of recovery, then I do/don't want....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want....

I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list of the treatments about which you may leave instructions.

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- psychosurgery
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker, before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. **You do not need a lawyer to fill out this form.**

You can choose any adult (over 18), including a family member, or close friend, to be your agent. If you select a doctor as your agent, he or she may have to choose between acting as your agent or as your attending doctor; a physician cannot do both at the same time.

Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask staff at the facility to explain those restrictions.

You should tell the person you choose that he or she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object. You can cancel the control given to your agent by telling him or her or your health care provider orally or in writing.

Filling Out the Proxy Form

Item (1) Write your name and the name, home address and telephone number of the person you are selecting as your agent.

Item (2) If you have special instructions for your agent, you should write them here. Also, if you wish to limit your agent's authority in any way, you should say so here. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

Item (3) You may write the name, home address and telephone number of an alternate agent.

Item (4) This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire.

Item (5) You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Two witnesses at least 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.

New York State Department of Health 1991

Health Care Proxy

(1) I, _____
(your name)

appoint _____
(name, home address and telephone number of agent)

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. Note that unless your agent knows your wishes about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration. (Attach additional pages if necessary.)

_____

_____

_____

_____

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

_____
(name, home address and telephone number of substitute)

_____

_____

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific date or conditions, if desired):

_____

_____

(5) Signature _____

Address _____

Date _____

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 _____

Address _____

Witness 2 _____

Address _____

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Important Facts Regarding Your Authorization to Share Protected Health Information

- In order to comply with Federal HIPAA regulations health plans must obtain a member's permission to share his/her protected health information with any other person. There are limited exceptions to this.

- As permitted by law, we will continue to communicate to providers of care involved in your treatment: (1) our payment activities in connection with your claims, (2) your enrollment in our health plan and (3) your eligibility for benefits.

- Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents do not have access to diagnosis or treatment information for sexually transmitted diseases, abortion, HIV/AIDs and drug or alcohol abuse unless the child specifically authorizes the release of such information.

- This form is used to authorize us to share your protected health information. Each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period.

- We will NOT disclose information relating to genetic testing, substance use disorder, mental health, abortion, and sexually transmitted disease information unless you initial the corresponding condition in Part D. If you would like to authorize us to release information regarding HIV/AIDS, New York State requires that a different form be completed. To obtain a copy of this form, please contact our office at the telephone number listed on your identification card, or access the form at the following website: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm.

- If you need additional forms, you may copy this form, contact our office at the telephone number listed on your identification card or visit our Web site at https://www.excellusbcbs.com and search for "Manage Your Privacy".

- Please ensure you have fully completed the form so that we may honor your request.

RETAIN A COPY FOR YOUR RECORDS

AUTHORIZATION TO EXCELLUS HEALTH PLAN, INC. ("HEALTH PLAN") TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

☐ **Check here only if you are authorizing access to psychotherapy notes. If checked, this form cannot be used for any other purpose. You must complete a separate form for authorizing access to any other information. If this box is checked, skip Part D.**

PLEASE PRINT

PART A: MEMBER/INDIVIDUAL WHO IS THE SUBJECT OF THE INFORMATION TO BE DISCLOSED				
LAST NAME	FIRST NAME	MI	DATE OF BIRTH	IDENTIFICATION # - located on ID card(s)

CURRENT ADDRESS	CITY	STATE/ZIP CODE

PART B: HEALTH PLAN CAN SHARE MY INFORMATION WITH THE FOLLOWING PERSON(S)	
NAME OF PERSON/ORGANIZATION	ADDRESS
NAME OF PERSON/ORGANIZATION	ADDRESS

PART C: REASON FOR MEMBER/INDIVIDUAL (PART A) AUTHORIZING DISCLOSURE

☐ At my request ☐ Other: _____

PART D: HEALTH PLAN CAN SHARE THE FOLLOWING INFORMATION *(select D-1 **or** D-2 and if applicable, D-3)*
NOTE: Skip this section if psychotherapy was checked at the top of this form

D-1. ☐ I would like you to disclose any information requested by the person or entity named in Part B. This includes information in Part D-3 (below) only if I placed my initials next to the condition. If my initials do not appear in D-3, information related to those conditions will not be disclosed.

- OR –

D-2. I would like to limit the disclosure of information to a specific type of information, provider, condition or date(s). If this area is blank I do not wish to limit the disclosure of my information.

☐ Enrollment *(e.g. eligibility, address, dependents, birth date)*
☐ Benefit *(e.g. benefit coverage, usage, limits)*
☐ Claim *(e.g. status, provider, dates, payment, diagnosis)*
☐ Clinical records *(e.g. doctor/facility, case management)*
☐ Other limitation: _____
☐ Date Range _____ to _____

- AND, IF APPLICABLE -

D-3. Unless specifically indicated below, information will not be disclosed related to the following conditions. If I have placed my initials next to one or more of these conditions, the Health Plan is authorized to disclose information related to those conditions.

____ Genetic testing
____ Sexually transmitted diseases
____ Substance use disorder
____ Abortion
____ Mental health *(excluding psychotherapy notes)*

Note: A separate form must be completed in order to authorize release of information related to HIV/AIDS. The NYS approved form can be found at http://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm

CONTINUED ON THE NEXT PAGE

PART E: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

I understand that:

- I can revoke this authorization at any time by writing to the Health Plan at the address listed below except this revocation would not affect any action taken by the Health Plan in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.
- Health Plan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on my giving this authorization.
- Unless you receive revocation in writing, this authorization will be valid until the date specified here: _____

IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form.

Signature: _____ Date: _____

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative's Name: _____

Personal Representative Signature _____

Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other * _____

** You must provide documentation supporting your legal authority to act on behalf of the member*

RETURN TO:

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

or Fax: 315-671-7079

Please keep a copy for your records

THE NEW YORK CONSUMER GUIDE TO HEALTH INSURERS

The New York Consumer Guide to Health Insurers
evaluates the performance of HMOs and other insurers.

TO OBTAIN YOUR FREE COPY, WRITE TO:

New York State Department of Financial Services
Publications Unit
Agency Building One, 5th Floor
Albany, New York 12257

Or e-mail your request to:
Publicat@dfs.ny.gov

Guides are also available through the
New York State Department of Financial Service's Website:
www.dfs.ny.gov

Please send a copy of the current *New York Consumer Guide to Health Insurers* to:

NAME: _____

ADDRESS: _____

CITY/STATE: _____

ZIP CODE: _____

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

165 Court Street
Rochester, New York 14647

NOTICE OF PRIVACY PRACTICES

This notice takes effect April 14, 2003 and describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

OUR COMMITMENT TO YOUR PRIVACY

We understand that medical information about you and your health is personal. We are committed to safeguarding your protected health information (PHI).

PHI is any information that can identify you as an individual and your past, present or future physical or mental health condition.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. The law requires us to:

- make sure that PHI that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to PHI about you; and
- follow the terms of the notice that is currently in effect.

OUR LEGAL DUTY

We **(Excellus BlueCross BlueShield)** are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning PHI. We must follow the privacy practices that are described in this notice while it is in effect, including notification should there be a breach of your unsecured PHI.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the contact information at the end of this notice.

Uses and Disclosures of Nonpublic Personal Information

Nonpublic Personal Information is information you give us on your enrollment form, claim forms, premium payments etc. For example: names, member identification number, social security number, addresses, type of health care benefits, payment amounts, etc.

We will not give out your nonpublic personal information to anyone unless we are permitted to do so by law or have received a signed authorization form from the member. You may revoke this authorization in writing by completing an authorization cancellation form at any time. This revocation will not affect any actions we took in reliance on your authorization before your authorization cancellation form was processed.

Uses and Disclosures of Medical Information

The following categories describe different purposes for which we use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. If we need to use or disclose your PHI in any other way, we will obtain your signed authorization before our use or disclosure. In addition, certain federal and state laws require that we limit how we disclose certain information considered sensitive in nature, such as HIV/AIDS, mental health, substance use disorder, and sexually transmitted diseases. Unless otherwise permitted under applicable laws, we will not disclose such sensitive information without your written consent. You may revoke an authorization or consent, referenced above, in writing by completing a cancellation form at any time. This revocation will not affect any actions we took in reliance on your authorization or consent before your cancellation form was processed.

We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.

Treatment: We may disclose PHI to doctors or hospitals involved in your care. For example, we may disclose your medications to an emergency room physician so that he/she can avoid dangerous drug interactions. This allows providers to manage, coordinate and administer treatment.

Payment: We may use and disclose PHI to collect premiums, to determine our responsibility to pay claims or to notify members and providers of our claim determinations. We may disclose PHI to providers to assist them in their billing and collection efforts. We may also disclose PHI to other insurance companies to coordinate the reimbursement of health insurance benefits. For example, we may disclose PHI to an automobile no-fault insurance company to determine responsibility for claim payment. Also, if you have health insurance through another insurance company, we may disclose PHI to that other health insurance company in order to determine which company holds the responsibility for your claims.

Healthcare Operations: We may use and disclose PHI for purposes of performing our healthcare operations. Our healthcare operations include using PHI to determine premiums, to conduct quality assessment and improvement activities, to engage in care coordination or case management, to determine eligibility for benefits. For example, we may use or disclose PHI when working with accreditation agencies that monitor and evaluate the quality of our benefit programs.

To You: We must disclose your PHI to you, as described in the Individual Rights section of this notice, below. We may also use and disclose PHI to tell you about recommended possible treatment options or alternatives or to tell you about health-related benefits or services that may be of interest to you.

To Family and Friends: If you agree or, if you are unable to agree when the situation, (such as medical emergency or disaster relief), indicates that disclosure would be in your best interest, we may disclose PHI to a family member, friend or other person. In an emergency, we will only disclose the minimum amount necessary.

To Our Business Associates: A business associate is defined as someone that assists us in managing our business. For example, a professional that reviews the quality of our products and services. We may disclose PHI to another company that helps us manage our business. For example, we may disclose PHI to a company that performs case reviews to ensure our members receive quality care. These business associates are required to sign a confidentiality agreement with us that limits their use or disclosure of the PHI they receive.

To Plan Sponsors: A plan sponsor is defined as the employer or employee organization that establishes and maintains the employee's benefit plan. If you are enrolled in a group health plan, we may disclose PHI to the plan sponsor to permit the plan sponsor to perform plan administrative functions. For example, the cost analysis of the benefit program. Before PHI is disclosed to your plan sponsor, we will receive certification from the plan sponsor that appropriate amendments have been made to group health plan document(s) and the plan sponsor agrees to limit their use or disclosure of this information to plan

administration functions only.

Research: We may use or disclose PHI for research purposes in limited circumstances. For example, a research project may involve comparing the health and recovery of all members who received one medication to those who received another medication for the same condition. All research projects are required to obtain special approval.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release PHI about deceased members to funeral directors for them to carry out their duties.

Organ Donation: If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, to facilitate organ or tissue donation and transplantation. This may include a living donor as well as a deceased donor.

Public Health and Safety: We may disclose PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose PHI to a government agency authorized to oversee the healthcare system or government programs or its contractors, and to public health authorities for public health purposes.

Victims of Abuse, Neglect or Domestic Violence: We may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Required by Law: We may use or disclose PHI when we are required to do so by law. For example, we must disclose PHI to the U.S. Department of Health and Human Services upon request to determine if we are in compliance with federal privacy laws.

Process and Proceedings: We may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose PHI to law enforcement officials.

Law Enforcement: We may disclose PHI to a law enforcement official investigating a suspect, fugitive, material witness, crime victim or missing person. We may disclose PHI of an inmate or other person in lawful custody of a law enforcement official or correctional institution under certain circumstances.

Military and National Security: We may disclose to the military, PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence, and other national security activities.

Marketing and Fundraising: To the extent we use PHI for marketing or fundraising purposes, you will be contacted by us and have the right to opt out of receiving these communications from us and our use of your information for such purposes.

Genetic Nondiscrimination Act (GINA): We will not disclose your PHI containing genetic information for underwriting purposes. GINA expressly prohibits the use or disclosure of genetic information for these purposes.

Breach of Unsecured Information: We are required to notify you if there is any acquisition, access, use, or disclosure of your unsecured PHI that compromises the security or privacy of your PHI.

Psychotherapy Information: Should it be applicable that your psychotherapy notes be included in an appropriate use or disclosure of information, in most instances, we are required to obtain your authorization for the release of this information.

Individual Rights

Access: You have the right to inspect and/or copy your PHI, with limited exceptions such as information a licensed health care professional, exercising professional judgment, determines that providing access is reasonably likely to endanger the life, physical safety or cause someone substantial harm. If you request copies, we reserve the right to charge you a reasonable fee for each copy, plus postage if the copies are mailed to you. You may contact us using the telephone number on the back of your member card to obtain a form to be completed and returned to us.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your PHI. The list will not include disclosures we made for the purpose of treatment, payment, healthcare operations, disclosures made with your authorization, or certain other disclosures. The request may not exceed a six year time period. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed and the reason for the disclosure. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. To request a disclosure accounting you may contact us using the telephone number on the back of your member card to obtain a form to be completed and returned to us.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. As permitted by law, we will not honor these requests, as it prohibits us from administering your benefits.

Confidential Communication: You have the right to request that we communicate with you confidentially about your PHI. We will honor a request to communicate to an alternative location if you believe you would be endangered if we do not communicate to the alternative location. We must accommodate your request if it is reasonable and specifies the alternative location. To request a form to be completed and returned to us, you may contact us using the telephone number on the back of your member card.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or if we determine the information is accurate. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be attached to the information you wanted amended. You may contact us using the telephone number on the back of your member card to obtain a form to be completed and returned to us.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the contact information at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the contact information below.

If you are concerned that we may have violated your privacy rights, as described above, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us confidentially communicate with you at an

alternative location, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. Upon request, we will provide you with the address for the U.S. Department of Health and Human Services.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Rights or Questions:

Contact Office: Customer Care

Phone: Please call the telephone number on your member card.

Privacy Complaints:

Contact Office: Corporate Privacy Officer
Address: 333 Butternut Dr.
Syracuse, NY 13214-1803

Phone: 1-866-584-2313

E-mail: privacy.officer@excellus.com

Excellus
165 Court Street, Rochester, New York 14647

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We Are Here for You

For Questions or for a printed copy of the provider directory, call Member Services at 1-800-650-4359

TTY: 1-800-662-1220

You can also get a list of providers on our website at www.excellusbcbs.com