SYRACUSE UNIVERSITY

# SYRACUSE UNIVERSITY MEDICAL BENEFITS

## SUBLUE

## SUORANGE

## SUPRO

Effective January 1, 2024

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# INTRODUCTION

This booklet describes certain provisions of the Syracuse University Medical Benefits Plan ("Active Plan"), the Syracuse University Retiree Medical Benefits Plan, and for those eligible, the Retiree Prescription Drug Plan ("Retiree Plan"). The booklet is intended to be read with, and considered as part of, the Active Plan and the Retiree Plans. This booklet also forms part of the summary plan description for the Active Plan and the Retiree Plan. Because the booklet is considered part of both the Active Plan and the Retiree Plan, when the term "Plan" is used in the booklet, such term refers to the Active Plan with respect to coverage provided under the Active Plan, and the Retiree Plan, with respect to coverage provided under the Retiree Plan. If there are any inconsistencies between this booklet and the plan documents, the plan documents will govern. No oral interpretations can change this Plan.

Syracuse University ("Employer") fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions and eligibility.

The Plan described in this booklet is designed to protect Covered Persons against certain catastrophic health expenses. The Plan may not pay for all treatments that a Covered Person receives. Neither the Plan, Employer, nor Claims Administrator decide what care a Covered Person needs or receives. The Covered Person and his or her provider make those decisions.

Coverage under the Plan will take effect for an eligible Participant and Qualifying Dependents when the eligible Participant and such Qualifying Dependents satisfy all the eligibility requirements of the Plan. The summary plan description for the Plan describes all of the eligibility requirements for the Plan. Failure to follow the eligibility or enrollment requirements of the Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other benefit management requirements, Medical Necessity, failure to timely file claims, or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan after the expiration of three (3) years after the date you received the service for which you want the Plan to pay.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Allowed Charges incurred before termination, amendment or elimination.

This document describes the Plan rights and benefits for Covered Persons and is divided into the following parts:

**Medical Necessity and Preauthorization.** Explains the methods used to curb unnecessary and excessive charges.

**Comprehensive Medical Benefits.** Explains when the benefit applies and the types of charges covered.

**Defined Terms.** Defines those Plan terms that have a specific meaning. If a word or phrase has a specific meaning, it starts with a capital letter and is either defined in the Defined Terms section or in the text of this document where it occurs.

**Plan Exclusions.** Shows what charges are **not** covered.

**Claim Provisions.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Medicare Integration When Medicare Is Primary**. Explains how the Plan coordinates with Medicare.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

**Continuation Coverage Rights Under COBRA.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.

**Miscellaneous Provisions**. Explains when the Plan can recover for clerical errors, misrepresentations and overpayment of benefits, as well as other miscellaneous provisions.

**Appendices.** Contains the Schedules of Benefits for SUBlue, SUOrange, and SUPro, outlines of the Plan reimbursement formulas and payment limits on certain services, and a list of services requiring preauthorization.

# MEDICAL NECESSITY AND PREAUTHORIZATION
# (Applies to SUBlue, SUOrange, and SUPro)

## CARE MUST BE MEDICALLY NECESSARY

The Plan will provide coverage for Covered Services and Supplies described in this booklet as long as the hospitalization, care, service, technology, test, treatment, drug or supply (collectively "Service") is Medically Necessary.

The fact that a Professional Provider or Provider of Additional Health Services has furnished, prescribed, ordered, recommended, or approved the Service does not make it Medically Necessary or mean that the Plan has to provide coverage for it.

The Claims Administrator has the right to decide, in its discretion, if a Service is Medically Necessary. The Claims Administrator will base its decision in part on a review of your medical records and will also evaluate any medical opinions it receives. 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, the Claims Administrator may also consider:

**(1)** Reports in peer reviewed medical literature;

**(2)** Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;

**(3)** Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment;

**(4)** The opinion of health professionals in the generally recognized health specialty involved;

**(5)** The opinion of the attending Professional Provider or Provider of Additional Health Services, which will be given credence but will not be considered to overrule contrary opinions; and

**(6)** Any other relevant information brought to its attention.

Services will be deemed Medically Necessary only if:

**(1)** They are appropriate and consistent with the diagnosis and treatment of your medical condition;

**(2)** They are required for the direct care and treatment or management of that condition;

**(3)** If not provided, your condition would be adversely affected;

**(4)** They are provided in accordance with community standards of good medical practice;

**(5)** They are not primarily for the convenience of you, your family, the Professional Provider, Provider of Additional Health Services or another Provider;

**(6)** 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

**(7)** 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).

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

## UTILIZATION REVIEW

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

**(1)** **Preauthorization of Medical Necessity**
If Services are rendered by an In-Network Provider, in most cases (see details below) your In-Network Provider is responsible for requesting Preauthorization for certain Services. The list of Services requiring Preauthorization is available at www.excellusbcbs.com/syredu. You may also request a paper copy of the list by calling the customer service number listed on your identification card. If the Services are rendered by an Out-of-Network Provider, you must request Preauthorization for the requested Services, and you should ask your Out-of-Network Provider for specific information regarding the name and the corresponding procedure code(s) for the Services that are proposed, so that you can accurately determine which Services are subject to Preauthorization. The list of Services is subject to change and is updated from time to time. To verify whether or not a specific Service requires Preauthorization, your In-Network Provider (or you, with respect to an Out-of-Network Provider) must contact the customer service number listed on your identification card.

**Preauthorization is not a promise or offer to you or your Provider to pay benefits, does not guarantee benefits to you or your Provider and will not result in payment of benefits that would not otherwise be payable. It is a preliminary review based entirely on the limited information provided to the Claims Administrator at the time of the requested Service authorization. All claims are subject to review to decide whether Services are covered according to Plan limitations and exclusions in force at the time Services are rendered. Preauthorization does not create a contract between the Plan and you or your Provider, between the Employer and you or your Provider, or between the Claims Administrator and you or your Provider.**

**(2)** Retrospective review of the Medical Necessity of the listed Services provided on an emergency basis;

**(3)** Concurrent review, based on the admitting diagnosis, of the listed Services requested by the attending physician; and

**(4)** Certification of Services and planning for discharge from a Facility or cessation of medical treatment.

The attending physician does not have to obtain preauthorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

## HERE'S HOW THE PROGRAM WORKS

**Preauthorization**
Before a Covered Person enters a Facility on a non-emergency inpatient basis or receives other medical Services that require preauthorization, the Claims Administrator will, in conjunction with the attending physician, certify the care as appropriate. A non-emergency stay in a Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from you or your Provider. The party responsible for making that telephone call depends upon the type of Provider who is providing the services. If the Provider is:

(1) An In-Network Provider in the Service Area, the Provider is responsible for calling the Claims Administrator.

(2) An In-Network Provider outside of the Service Area that is a Facility, the Provider is responsible for calling the Claims Administrator.
(3) An In-Network Provider outside of the Service Area that is not a Facility (for example, a Professional Provider), you are responsible for calling the Claims Administrator.
(4) An Out-of-Network Provider, you are responsible for calling the Claims Administrator.

The responsible party, as described above, must contact the Claims Administrator at the telephone number on your identification card **at least seven (7) days before** Services are scheduled to be rendered; or, if you are hospitalized in cases of an **Emergency Medical Condition, within 24 hours** of the first business day after the admission.

After receiving a request, the Claims Administrator will review the reasons for your planned treatment. Criteria will be based on multiple sources which may include medical policy, clinical guidelines and pharmacy and therapeutic guidelines. The Claims Administrator will notify you and your Provider of the decision by telephone and in writing within three (3) business days after receipt of all necessary information. If your treatment involves continued or extended health care Services, or additional Services for a course of continued treatment, the Claims Administrator will notify you and your Provider within one (1) business day after receipt of all necessary information.

**Concurrent Review, Discharge Planning**
Concurrent review of a course of treatment and discharge planning from a Facility are parts of the utilization review program. The Claims Administrator will monitor the Covered Person's Facility stay or use of other medical Services and coordinate with the attending physician, Facility and Covered Person either the scheduled release or an extension of the Facility stay or extension or cessation of the use of other medical Services.

If the attending physician feels that it is Medically Necessary for a Covered Person to receive additional Services or to stay in the Facility for a greater length of time than has been preauthorized, the attending physician must request the additional Services or days.

**Failure to Seek Preauthorization**
If your Provider is the responsible party, as described above, and fails to seek prior approval for benefits subject to this section, other than with respect to any benefits received due to an Emergency Medical Condition, the Plan will not provide any coverage for those Services; however, you will be held harmless and not subject to any penalties. If you are the responsible party, as described above, and fail to seek prior approval for Services no penalty will apply; however, the Plan will pay the Allowed Charge, less any Cost-Sharing, only for Services that are determined to be Medically Necessary. If it is determined that the Services were not Medically Necessary, you will be responsible for paying the entire charge for the service.

**Your Right to Appeal**
If you or your Provider disagrees with the Claims Administrator’s decision, you may appeal by following the procedures set forth in **Claim Provisions** section of this booklet.

**CASE MANAGEMENT**

The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits. If the Covered Person agrees to participate and abide by the policies of the Plan and the Claims Administrator, in addition to benefits specified under this booklet, the Covered Person may be provided, outside the terms of this Plan, benefits for Services pursuant to the alternative treatment plan of the Claims Administrator for a Covered Person.

The Plan may provide such alternative benefits if and only for so long as the Claims Administrator determines, among other things, that the alternative Services are Medically Necessary, cost-effective and feasible, and that the total benefits paid for such Services do not exceed the total benefits to which the Covered Person would otherwise be entitled under the Plan in the absence of alternative benefits.

The alternative benefits, called “Case Management”, shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

The alternative benefits a Covered Person receives will be in lieu of the benefits the Plan would normally provide to a Covered Person under this booklet for the treatment of his/her condition. As a result, the Plan may require the Covered Person to agree to waive certain benefits in order to receive the alternative benefits agreed upon. The Covered Person may return to utilization of benefits at any time upon prior written notice to the Claims Administrator. However, the benefits remaining available to the Covered Person will be reduced in a manner that appropriately reflects the alternative benefits used.

A case manager consults with the patient, the family and the attending physician in order to develop a plan of care for approval by the patient's attending physician and the patient. This plan of care may include some or all of the following:

**(1)** personal support to the patient;
**(2)** contacting the family to offer assistance and support;
**(3)** monitoring Hospital or Skilled Nursing Facility;
**(4)** determining alternative care options; and
**(5)** assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternative benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Claims Administrator, attending physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Claims Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

**Appeals of Case Management**
If you or your Provider disagrees with the Claims Administrator’s decision, you may appeal by following the procedures set forth in **Claim Provisions** section of this booklet.

**ACCESS TO CARE**

**Authorization to an Out-of-Network Provider.** If there is not an In-Network Provider that has the appropriate training and experience to treat the Covered Person’s condition, the Plan may approve an authorization to an appropriate Out-of-Network Provider. You or your In-Network Provider must request prior approval of the authorization to a specific Out-of-Network Provider. Approvals of authorizations to Out-of-Network Providers will not be made for the convenience of you or another treating provider and may not necessarily be to the specific Out-of-Network Provider you requested. If the authorization is approved by the Plan, all services performed by the Out-of-Network Provider are subject to an approved treatment plan in consultation with the Claims Administrator, your primary care physician, the Out-of-Network Provider and you. The Claims Administrator will work with the proposed Out-of-Network Provider to determine if the Out-of-Network Provider satisfies the criteria for approval of an authorization by the Claims Administrator. You will be responsible only for the Cost-Sharing applicable to In-Network Providers. In the event an

authorization is not approved, any services rendered by an Out-of-Network Provider will be covered as an Out-of-Network Benefit.

The rules in this Access to Care section apply only in situations where there is not an In-Network Provider that has the appropriate training and experience to treat the Covered Person's condition. Different rules, explained in other sections of this booklet, apply when an Out-of-Network Provider performs certain services for an Emergency Medical Condition, non-emergency services in certain In-Network facilities, or provides air ambulance services.

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

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

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

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

**(1)** You are undergoing a course of treatment for a serious and complex condition. Serious and complex condition means:
   a. An acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
   b. A chronic illness that is life threatening, degenerative, potentially disabling or congenital and requires specialized medical care for a prolonged period of time.

**(2)** Undergoing a course of institutional or inpatient care from the Provider.

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

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

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

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

The above requirements became applicable to the Plan effective January 1, 2022.

## AFTER-HOURS CARE AND EMERGENCY SERVICES

If you get sick or hurt and need care after regular business hours, call your doctor's office first, unless it is an emergency medical condition. Your medical doctor/ primary care provider (PCP) may use an answering service or another doctor who is on call to make sure you receive medical care when you need it. Your PCP or the on-call doctor will decide if you need treatment right away or if you can wait for regular office hours. For additional information on how to obtain care after normal business hours or when to use and how to access emergency services, please call the telephone number listed on your identification card or visit https://hr.syr.edu/benefits/health-benefits/medical.

## YOUR RIGHTS AND RESPONSIBILITIES

**(1)** You have a right to receive information about the Claims Administrator, its services, the practitioners and providers it contracts with on behalf of the Plan and your rights and responsibilities.
**(2)** You have a right to be treated with respect and recognition of your dignity and your right to privacy.
**(3)** You have a right to participate with practitioners in making decisions about your health care.
**(4)** You have a right to a candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
**(5)** You have a right to voice complaints or appeals about the Claims Administrator or the care it provides.
**(6)** You have a right to make recommendations regarding the Claims Administrators rights and responsibilities policy.
**(7)** A responsibility to supply information (to the extent possible) that the Claims Administrator and the practitioners and providers it contracts with on behalf of the Plan need in order to provide care.
**(8)** A responsibility to follow plans and instructions for care that you have agreed to with practitioners.
**(9)** A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

## HOW TO MAKE A COMPLAINT

A complaint applies to any issues not related to a claim, or an internal or external appeal. For information on how to submit a complaint, please call the telephone number listed on your identification card. You may file a claim, orally, by contacting the telephone number listed on your identification card; in writing, by mailing your complaint to Excellus BlueCross BlueShield, CAU P.O. Box 4717, Syracuse, NY 13221; or, by facsimile at 315-671-6656.

## HOW TO OBTAIN LANGUAGE ASSISTANCE

If you do not speak English well and require assistance in your native language to understand your rights and responsibilities under the Plan, please call the Claims Administrator at the telephone number listed on your identification card. If you are hard of hearing, TTY/TDD assistance is also available.

# COMPREHENSIVE MEDICAL BENEFITS

**Comprehensive Medical Benefits** apply when Covered Services and Supplies are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

All benefits described in the Schedule of Benefits are subject to the exclusions and limitations described more fully herein including, but not limited to, the Claims Administrator's determination that: care and treatment is Medically Necessary and that services, supplies and care are not Experimental and/or Investigational (the meanings of the terms “Medically Necessary” and “Experimental and/or Investigational” are set forth in the **Defined Terms** section of this document). In addition, in order for an expense to be covered under the Plan, it must qualify as an expense for “medical care” as defined under Section 213(d) of the Internal Revenue Code.

See the **Medically Necessary and Preauthorization** section of this booklet for details on which services must be preauthorized.

See **Coordination of Benefits** and **Medicare Integration When Medicare is Primary** for details on Plan payment when the person is covered under more than one plan.

This document is intended to describe the benefits provided under the Plan, but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Claims Administrator if you have questions about specific supplies, treatments or procedures that may be covered or excluded.

## VERIFICATION OF ELIGIBILITY

Call the customer service number listed on your identification card to verify eligibility for Plan benefits before any charges are incurred.

Note: Certain services must be preauthorized or reimbursement from the Plan may be reduced; however, you will be held harmless for any reduction in reimbursement due to your In-Network Provider’s failure to have a service preauthorized. The attending physician does not have to obtain preauthorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Please see the **Medically Necessary and Preauthorization** section of this booklet for details.

### In-Network Providers

In-Network Providers include a Facility, Professional Provider or Provider of Additional Health Services that have entered into an agreement with the Claims Administrator or another Blue Cross and/or Blue Shield plan to provide health care services to you. In-Network Providers have agreed to accept negotiated rates. The Plan can (in most instances) afford to reimburse a higher percentage of their fees and agrees to reimburse the In-Network Provider directly for Covered Services and Supplies.

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive higher benefits from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use. In certain circumstances described elsewhere in this booklet (see “**SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS**” below), special rules apply to benefits payable to Out-of-Network Providers.

Additional information about this option, as well as a list of In-Network Providers, will be available to Covered Persons, at no cost, by contacting the customer service number listed on your identification card or by visiting www.excellusbcbs.com/syredu.

**Primary Care Providers**
Under the Plan, you have the right to select any Primary Care Physician who participates in the network and who is available to accept you or your family members. For children, you may select a pediatrician as the Primary Care Physician. Official designation of a Primary Care Physician is not required. For information on how to select a Primary Care Physician, and for a list of the participating Primary Care Physicians, contact the customer service number listed on your identification card or visit www.excellusbcbs.com/syredu.

**Coordination of Benefits**
Coordination of Benefits rules apply when services and supplies are rendered and billed by an In-Network Provider or Out-of-Network Provider and the Covered Person is covered under another plan or policy that may be primary or secondary to this Plan. See section, **Coordination of Benefits**.

**BENEFIT PAYMENT**

Each Calendar Year, benefits will be paid for the Allowed Charges of a Covered Person minus any applicable Deductible, Copayment, and/or Coinsurance amounts. Payment rates and member responsibility are shown in the Schedules of Benefits for SUBlue, SUOrange, and SUPro (Appendices A, B, and C of this booklet). No benefits will be paid in excess of any Allowed Charge or listed limit of the Plan.

**Covered Charges**
Covered charges are the Allowed Charges that are incurred for the Covered Services and Supplies described in this booklet. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. Charges are incurred on the date that the service or supply is performed or furnished.

The Plan will not pay charges that exceed the Allowed Charge. The Covered Person is responsible for payment of any charges that are excluded under the Plan or in excess of the Allowed Charge. See Allowed Charge in **Defined Terms** for more information.

**Deductible Amount**
The Deductible is a charge, expressed as a fixed dollar amount, that you must pay for certain Covered Services and Supplies before benefits will be provided under the Plan each Calendar Year. The Deductible amounts are shown in the **Appendices - Schedule of Benefits** section of this booklet**.**

The Deductible amounts will accrue toward the Out-of-Pocket Limits shown in the **Appendices – Schedule of Benefits** section of this booklet.

Family Unit Limit. When the family maximum amount, shown in the **Appendices - Schedule of Benefits** section of this booklet, has been incurred by members of a family unit toward their individual Calendar Year Deductibles, the Deductibles of all members of that family unit will be considered satisfied for that Calendar Year.

Deductible for a Common Accident. This provision applies when two (2) or more Covered Persons in a family unit are injured in the same accident. These persons need not meet separate Deductibles for treatment of injuries incurred in this accident; instead, only one Deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

**Copayment Amount**
A Copayment is a predetermined charge, expressed as a fixed dollar amount, that you must pay each time a particular service is rendered. Typically, there may be Copayments on some services and other services will not have any Copayments. You are responsible for payment of any Copayments directly to the Provider when services are rendered. Copayments accrue toward the Out-of-Pocket Limits shown in the **Appendices – Schedule of Benefits** section of this booklet.

**Coinsurance Amount**
Coinsurance is a charge, expressed as a percentage of the Allowed Charge, that you must pay for certain services under the Plan. The Covered Person is responsible for payment of any Coinsurance balance not paid by the Plan. Coinsurance payments accrue toward the Out-of-Pocket Limit shown in the **Appendices – Schedule of Benefits** section of this booklet. For services that are subject to "surprise billing" rules, the Coinsurance charge that you must pay will be based on the Recognized Amount (as defined in Defined Terms). Please refer to the section entitled "SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS" for a description of the services that are subject to these rules.

**Out-of-Pocket Limit**
The Out-of-Pocket Limit is the most you pay during a Calendar Year for Covered Services and Supplies in Coinsurance, Copayments and Deductibles before the Plan begins to pay 100% of the Allowed Charge. The Out-of-Pocket Limit is shown in the **Appendices - Schedule of Benefits** section of this booklet.

When a family unit reaches the Out-of-Pocket Limit, Covered Services and Supplies for that family unit will be payable at 100% of the Allowed Charge.

Any amounts you pay that are in excess of the Allowed Charge and the Provider's actual charge will not accrue toward the Out-of-Pocket Limit.

**Lifetime Maximum Benefit Amount**
There is no Lifetime maximum benefit amount under this Plan, other than for specific services, such as wigs and treatment of infertility. Please see the **Appendices – Schedule of Benefits** section of this booklet for any Lifetime limits that apply to specific benefits.

**IN-NETWORK BENEFITS**

**SUBlue, SUOrange and SUPro**

**In-Network Benefits** will be paid for services which are provided by an In-Network Provider.

In-Network Providers typically accept the Allowed Charge (network allowance) as payment in full, after you pay any applicable Copayment, Coinsurance and/or Deductible, as shown in the **Appendices - Schedule of Benefits** section of this booklet.

For services other than the services identified under the "SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS" section below, if there is no In-Network Provider available for needed care or services, the Claims Administrator's case manager may approve, in advance, a referral to another Provider. The Claims Administrator will notify you in writing if the referral is approved or denied. If the Claims Administrator approves the referral as Medically Necessary, In-Network Benefits will be available; you will be responsible for any applicable Coinsurance, Copayment or Deductible for Covered Services and Supplies. The case manager will determine the Covered Services and Supplies on a case-by-case basis.

**SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS**

A surprise bill is a bill you receive for Covered Services and Supplies in the following circumstances:

- Emergency Services performed by an Out-of-Network Provider with respect to an Emergency Medical Condition.
- Certain Non-Emergency Services performed by an Out-of-Network Provider in an in-network Hospital (including a Hospital outpatient department), or Ambulatory Surgical Center.
- Air ambulance services provided by an Out-of-Network Provider.

When the above Covered Services and Supplies are provided by an Out-of-Network Provider, the rules described in this section will be applied to determine the Plan's payment and your responsibility for payment.

The special benefit payment rules described in this section will **always** apply to the following covered Non-Emergency Services performed by an Out-of-Network Provider in an in-network Hospital (including a Hospital outpatient department) or Ambulatory Surgical Center:

- Covered Services and Supplies related to emergency medicine, anesthesiology, pathology, radiology, and neonatology
- Covered Services and Supplies provided by assistant surgeons, hospitalists, and intensivists
- Diagnostic services, including radiology and laboratory services
- Covered Services and Supplies provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish the item or service in the in-network Hospital (including a Hospital outpatient department), or Ambulatory Surgical Center; and
- Covered Services and Supplies provided by an Out-of-Network Provider as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, even if you previously consented to the Out-of-Network Provider providing the item or service.

For other Non-Emergency Services provided by Out-of-Network Providers in an in-network Hospital (including a Hospital outpatient department) or Ambulatory Surgical Center, the special benefit payment rules described in this section will **not** apply if the Out-of-Network Provider has obtained your consent to receive the services after providing you with required notice and satisfying other consent requirements applicable to the Out-of-Network Provider. If the Out-of-Network Provider follows the requirements and you provide consent to receiving the services, the Plan's normal payment rules will apply with regard to those services. In addition, the special benefit payment rules described in this section will **not** apply when an In-Network Provider is available and you elected to receive services from an Out-of-Network Provider.

When these special benefit payment rules apply, for Covered Services and Supplies, the Plan will pay the Out-of-Network Provider an initial payment equal to the Allowed Charge. The Plan may later make an additional payment to the Out-of-Network Provider if the amount determined to be the Out-of-Network Rate (as defined in the Defined Terms section) exceeds the sum of the initial payment made by the Plan and the amount of Cost-Sharing you owe for the Covered Services and Supplies.

Your Cost-Sharing amount for Covered Services and Supplies that are subject to these rules will not be greater than the amount that you would have owed if the Provider had been an In-Network Provider. You will be held harmless for any Out-of-Network Provider charges that exceed your in-network Cost-Sharing. Any Coinsurance amount for Covered Services and Supplies that are subject to these rules will be determined as the applicable percentage of the Recognized Amount. Your Cost-Sharing payments will be counted toward your In-Network Deductible and Out-of-Pocket Limit.

The special benefit provisions in this section and elsewhere in this booklet are designed to comply with the group health plan requirements of the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021 (the "No Surprises Act"). Those requirements became applicable to the Plan effective January 1, 2022. The provisions are based on regulations published by the U.S. Department of the Treasury, Department of Labor, and Department of Health and Human Services (the "Departments") and will be interpreted to be consistent with those regulations. If the Departments issue additional guidance regarding the requirements of the No Surprises Act, the Plan will comply with the additional or modified requirements as required by the guidance and this booklet will be updated at a later date.

**OUT-OF-NETWORK BENEFITS**

The provisions described in this section apply to Covered Services and Supplies provided by Out-of-Network Providers that are not subject to the special Out-of-Network Benefits provisions described above.

**SUBlue and SUPro**

Out-of-Network Benefits will be paid for services rendered by Out-of-Network Providers. Out-of-Network Providers are Providers that have not entered into a contract with the Claims Administrator or another Blue Cross Blue Shield plan to provide services to Covered Persons. Out-of-Network Providers are not required to accept the Plan's payment of the Allowed Charge, as payment in full, after you pay any applicable Coinsurance, Copayment and/or Deductible as shown in the **Appendices - Schedule of Benefits** section of this booklet. You are also responsible for payment of any difference between the Allowed Charge and the Provider's actual charge.

**SUOrange**

Out-of-Network Benefits are not available under SUOrange, other than for Emergency Services, ambulance services, or Covered Services and Supplies provided by an Out-of-Network Provider in an In-Network facility. The Plan's benefits in these situations are described in the "**SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS**" section above.

**OUT OF COUNTRY CARE**

**SUBlue, SUOrange and SUPro**

**Blue Cross Blue Shield Global® Core**. If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard Service Area"), you may be able to take advantage of BCBS Global® Core when accessing covered healthcare services. BCBS Global® Core is unlike the BlueCard program available in the BlueCard Service Area in certain ways. For instance, although BCBS Global® Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard Service Area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard Service Area, you should call the BCBS Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

In most cases, if you contact the BCBS Global® Core service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your Cost-Sharing amounts. In such cases, the hospital will submit your claims to BCBS Global® Core service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services. You must contact the Claims Administrator to obtain precertification for non-emergency inpatient services.

Physicians, urgent care centers and other outpatient providers located outside the BlueCard Service Area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

When you pay for covered healthcare services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BCBS Global® Core claim form and send the claim form with the provider's itemized bill(s) to the BCBS Global® Core service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available by contacting the Claims Administrator, the BCBS Global® Core service center

or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the BCBS Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

**SUBlue and SUPro Only**

For Covered Services and Supplies incurred outside the USA that are not obtained through an In-Network Provider, Plan benefits will be based on the charges submitted by the Provider and on the currency exchange rate in effect at the time services are rendered. You may be required to pay the Provider at the time of service. If expenses outside the USA are incurred through an Out-of-Network Provider, you must submit a translation of the bill to include diagnosis, description of service, charge for each service (currency of the country if not in US dollars), date(s) of service, and name of country where service are rendered. Otherwise, usual Plan procedures for claim submissions should be followed. The Claim Administrator reserves the right to reimburse the Covered Person directly.

# PREVENTIVE CARE

Among the provisions of the Patient Protection and Affordable Care Act is expanded coverage for preventive care services. These standards will apply to services rendered by In-Network Providers only unless otherwise specified in the **Appendices - Schedule of Benefits** section of this booklet. Excellus' medical criteria may apply to frequency limitations.

Coverage is provided for routine preventive care as described in the Schedule of Benefits. The Plan will comply with all mandated coverage provisions of the Patient Protection and Affordable Care Act. The following is a list of the most common services. This list is subject to change based on evidence-based items or services with an "A" or "B" rating from the United States Preventive Services Task Force; evidence-informed preventive care and screenings for infants, children, adolescents and women provided in guidelines supported by the Heath Resources and Services Administration; and immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices (ACIP). The Plan will comply within the first Plan Year after one year of the effective date of all new recommendations or guideline changes. The Plan will not cover any item or service that is no longer a recommended preventive service. Ancillary charges associated with any preventive care service will be available to you without Cost-Sharing.

Please see www.HealthCare.gov/center/regulations/prevention.html for a complete listing of covered services and frequencies, unless listed in the **Appendices – Schedule of Benefits** section of this booklet.

Please note: If an In-Network Provider is not available (as determined by the Claims Administrator) for covered preventive care services, the Plan will provide coverage for 100% of charges. You will not be responsible for any Out-of-Network Provider Cost-Sharing.

**Routine Well Child Care:**

- **Well Newborn Nursery/Physician Care:** The benefit is limited to the Allowed Charges made by a physician for routine pediatric care for the first four (4) days after birth while the newborn child is Hospital-confined. Charges for a newborn's covered nursery and physician care are applied separately under the newborn's Plan and will not be applied toward the Plan of the covered parent.

- **Routine Well Child Care** is routine care by a physician that is not for an Injury or Sickness, and includes health care visits and immunizations. Covered Services and Supplies are shown in the **Appendices - Schedule of Benefits** section of this booklet and are intended to be consistent with the clinical standards and frequency recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices.

**Routine Well Adult Care.** Routine well adult care is care by a physician that is not for an Injury or Sickness.

- **Routine Adult Annual Physical Exams**, to include screening tests based on guidelines issued by the United States Preventive Services Task Force and age-appropriate immunizations based on ACIP recommendations (Advisory Committee on Immunization Practices). Coverage is limited to one (1) routine physical exam per Calendar Year.

  Covered immunizations are based on age and frequency limitations set forth by USPSTF guidelines.

- **Routine Colorectal Cancer Screening and Surveillance** for Covered Persons (1) at increased or high risk for developing colorectal cancer (based on specific personal or family health risk factors); or (2) at average risk, beginning at age 45.

  Coverage is intended to be consistent with the guidelines for early detection screening and surveillance testing for colorectal cancer set forth by the American College of Gastroenterology and American Society of Gastrointestinal Endoscopists.

- **Routine Mammography Screening for Breast Cancer.** An X-ray or digital examination is covered for:
  - Covered Persons of any age with a personal or family medical history of breast cancer as recommended by a physician; or
  - Covered Persons from age 35, limited to one (1) screening per Calendar Year.

- **Routine Osteoporosis Screening.** Bone mineral density measurement or test to detect osteoporosis is covered for Covered Persons:
  - Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
  - With symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis;
  - On a prescribed drug regimen posing a significant risk of osteoporosis;
  - With lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
  - With such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

- **Routine Gynecological Exam** for Covered Persons age 18 and older, limited to one (1) screening per Calendar Year, and age-appropriate cervical cancer screening tests to include:
  - Pelvic exam and Pap smear;
  - HPV-DNA test (according to FDA-approved guidelines for routine screening); and
  - Ancillary tests that may be rendered during the routine GYN exam are covered such as, but not limited to, a urinalysis.

- **Routine Prostate Cancer Screening**
  - Benefits are available for an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.
  - Benefits are also available for standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

- **Well-Woman Preventive Services**. In addition to mammography, pelvic exam and Pap smear, HPV- DNA testing, and contraceptive care, preventive care benefits for women also include:
  - Annual well-woman visits for adults to obtain all recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. Additional visits may be necessary to obtain all preventive services recommended by the United States Preventive Services Task Force, depending on the woman's health status and needs, and risk factors. These services include, but are not limited to, mammography and cervical cancer screening.
  - Comprehensive breastfeeding support and counseling by a trained provider during each pregnancy and/or in the postpartum period, including the in-network rental or purchase of breastfeeding equipment and related disposable supplies.
  - Annual screening and counseling for interpersonal and domestic violence.
  - Annual counseling and screening for human immune-deficiency virus (HIV) infection for all sexually active women.
  - Annual counseling for sexually transmitted infections for all sexually active women.
  - Screening for gestational diabetes (between 24 and 28 weeks of gestation and at the first prenatal visit for pregnancy women identified to be at high risk for diabetes).
  - **Birth Control Services**
    - The Plan covers FDA-approved injectable or implantable contraceptives, intrauterine devices (IUD), or diaphragms that are prescribed for Covered Persons and for the physician services related to the covered contraceptive.
    - Benefits are not provided for any drug or device obtainable without a prescription or for any contraceptive which is not FDA-approved. Male contraceptives are not covered.
    - Covered charges include physician or clinic contraceptive services, including the measuring, fitting or insertion of covered devices and the purchase of covered devices, are covered.
    - Benefits for oral contraceptives are provided under the separate prescription drug benefit.

- **Nutritional Counseling.** The Plan will cover wellness nutritional counseling (no underlying chronic condition required) up to a maximum of 26 visits per Calendar Year. Services must be rendered by a physician, certified nutritionist or certified and registered dietician. Nutritional therapy for chronic conditions is covered separately.

- **Tobacco Use Cessation Counseling.** The Plan covers charges related to tobacco use or smoking cessation counseling that is rendered by or prescribed by a physician. (Tobacco deterrent drugs and products are covered separately under the prescription drug benefit.)

- **Genetic Counseling**, to include related screening for BRCA1 or BRCA2 genes for women whose family history places them at increased risk for BRCA mutations. Genetic counseling for other conditions is covered separately.

- **COVID-19 Vaccine:** Effective as of 15 business days after a recommendation is made from the United States Preventive Services Task Force or CDC Advisory Committee on Immunization Practices, the Plan will provide coverage for vaccines and other services intended to prevent COVID-19.

**Routine Vision Care**

Vision care benefits apply when routine vision care charges are incurred by a Covered Person for services that are recommended and approved by a physician or licensed optometrist. Services include examination, refraction, testing, and evaluating the need for corrective lenses.

Benefits for vision care services are limited to one (1) exam during any 24-consecutive month period.

**Hearing Services**

- Benefits are payable for a routine audiometric examination rendered by a physician to measure hearing loss and determine the need for a hearing aid.

  Benefits for routine hearing services are limited to one (1) exam during any 24-consecutive month period.

- Hearing Aids:

  Hearing aid coverage is limited to $750 for a single hearing aid and $1,500 for binaural hearing aids, once every three (3) Calendar Years for Covered Persons of any age. Hearing aids are not an Essential Health Benefit.

**HOSPITAL AND OTHER FACILITIES**

This benefit applies when a Hospital charge is incurred for the care of a Covered Person's Injury or Sickness and during a Hospital confinement that starts while that person is covered for this benefit.

See **Medical Necessity and Preauthorization** section of this booklet for details on which services must be preauthorized.

**Inpatient Hospital (Acute Care, Nursery Care, Certified Birthing Center).** The medical services and supplies furnished by a Hospital or a Birthing Center.

**(1)** **Benefits for Room and Board Charges.** The charges for room and board including specialty care units are payable as described in the **Appendices - Schedule of Benefits**.

The Plan pays the average semi-private rate for room and board charges by a Hospital or other covered inpatient health Facility. If the Facility has several semi-private rates, the prevailing, or the most common rate, shall be used.

Charges for a private room will also be covered if a private room is deemed to be Medically Necessary.

**(2)** **Benefits for Special Charges (Miscellaneous Charges).** The Allowed Charges for Hospital-billed medical services and supplies (other than room and board) and diagnostic x-rays and lab tests are payable.

Claims for implants rendered by an Out-of-Network Provider may be denied unless they are submitted with the manufacturers' invoice. The claim submitted with the manufacturers' invoice will be reimbursed at 50% above the manufacturers' invoice amount, less any applicable Cost-Sharing. In addition to the applicable Cost-Sharing, you may be responsible for paying the difference between the Out-of-Network Provider's charge and the amount paid by the Plan.

**(3)** **Coverage of Pregnancy.** Pregnancy is covered the same as any other Sickness.

Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

If you choose to be discharged from the Hospital before the recommended time frames noted above, you are eligible for one (1) home health care visit by a qualified Home Health Care Agency. This visit is separate and does not apply to any visit limits set under any other home health care benefit. A home health care maternity visit must be requested within 48 hours of the time of delivery (96 hours in the case of cesarean delivery). The visit must be rendered within 24 hours of discharge, or at the time of the request, whichever is later. The visit should include parental education; assistance and training in breast or bottle feeding; and the performance of any necessary maternal and newborn clinical assessments. The charge for this visit is not subject to any applicable Coinsurance, Copayment or Deductible amounts.

In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours in the case of cesarean delivery).

**(4)** **Charges for Routine Nursery Care.** Routine well newborn nursery care is care while the newborn is Hospital confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This routine coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and/or the newborn child is an eligible Qualifying Dependent.

The benefit is limited to charges for nursery care for the first four (4) days after birth while the newborn

child is Hospital confined as a result of the child's birth.

**Outpatient Hospital Care** services and supplies payable are:

**(1)** **Preadmission Testing Service.** The Plan will provide coverage for diagnostic lab tests and x-ray exams when:

**(a)** performed on an outpatient basis before a Hospital confinement;

**(b)** related to the condition which causes the confinement; and

**(c)** performed in place of tests while Hospital confined.

Allowed Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

**(2)** **Emergency Room (Facility charge).** Care for the initial treatment of an Emergency Medical Condition or a non-Emergency Medical Condition.

**(3)** **Outpatient Surgery (Facility charge).**

**(4)** **Outpatient Therapy Services after an Injury or Sickness.**

**(a)** Radiation therapy.

**(b)** Chemotherapy.

**(c)** Intravenous therapy.

**(d)** Dialysis in a Hospital or Medicare-certified dialysis center.

**(e)** Physical therapy.

**(f)** Respiratory therapy.

**(g)** Speech therapy.

**(h)** Cardiac rehabilitation.

**(i)** Occupational therapy.

**(5)** **Outpatient Diagnostic Services.**

**(a)** Radiology, ultrasound and nuclear medicine, and necessary supplies.
**(b)** Laboratory and pathology.
**(c)** ECG, EEG, and other diagnostic medical and physiological medical testing procedures.

**(6)** **Clinic Services or Supplies.**

**(7)** **Other Services and Supplies** such as prescription medication, vaccines, and biologicals, and supplies in conjunction with diagnostic and therapeutic services, and their administration.

Claims for implants rendered by an Out-of-Network Provider may be denied unless they are submitted with the manufacturers' invoice. The claim submitted with the manufacturers' invoice will be reimbursed at 50% above the manufacturers' invoice amount, less any applicable Cost-Sharing. In addition to the applicable Cost-Sharing, you may be responsible for paying the difference between the Out-of-Network Provider's charge and the amount paid by the Plan.

**Ambulance Services.** Coverage is provided for a local land ambulance service for pre-transport services to evaluate and treat an urgent condition. An urgent condition is one that may become an Emergency Medical Condition in the absence of treatment. Coverage is also provided for local land and water ambulance transport to the nearest Hospital where necessary treatment can be provided unless the Claims Administrator finds a longer trip was Medically Necessary.

Coverage is also provided for air ambulance when the patient's condition is so serious that the patient cannot be transported safely by land ambulance. Coverage for air ambulance is also provided if the location for which the patient requires emergency transportation is inaccessible by land ambulance.

Charges for pre-transport services are covered under the Plan, regardless of whether or not the Covered Person is actually transported to a Hospital.

A Hospital, professional, or licensed volunteer ambulance must charge for its services to be covered.

**Ambulatory Surgical Center**, as defined, for outpatient surgery.

Claims for implants rendered by an Out-of-Network Provider may be denied unless they are submitted with the manufacturers' invoice. The claim submitted with the manufacturers' invoice will be reimbursed at 50% above the manufacturers' invoice amount, less any applicable Cost-Sharing. In addition to the applicable Cost-Sharing, you may be responsible for paying the difference between the Out-of-Network Provider's charge and the amount paid by the Plan.

**Mental Health Disorders.** Coverage is provided for care, supplies and treatment of Mental Health Disorders. The Plan shall comply with federal parity requirements. Coverage for care, supplies and treatment of Mental Health Disorders will be as follows:

**(1)** **Inpatient Treatment.** Services relating to the diagnosis and treatment of Mental Health Disorders comparable to other similar Hospital benefits will be covered. Coverage includes residential treatment and is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- **(a)** A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health; or
- **(b)** A state or local government run psychiatric inpatient Facility; or
- **(c)** A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health; or
- **(d)** A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

and, in other states, to similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator, and provide (at a minimum) those services and treatments identified in the most recent McKesson InterQual criteria for a psychiatric residential treatment center or in such other comparable criteria recognized by the Claims Administrator.

Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

**(2)** **Outpatient Treatment.** Coverage for care, supplies and treatment of Mental Health Disorders will be as follows:

- **(a)** Comprehensive psychiatric emergency programs performed on an outpatient basis.
- **(b)** Psychological testing.
- **(c)** Intensive outpatient program treatment.
- **(d)** Partial hospitalization.

**(e)** Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the Office of Mental Health and, in other states, to similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator; and services provided by a licensed psychiatrist or psychologist; a licensed social worker who has at least three (3) years of additional experience in psychotherapy; or a professional corporation or a university faculty practice corporation thereof.

**(f)** Except as otherwise excluded under this Plan, family counseling will be covered for a family member of the immediate family of a person diagnosed with a Mental Health Disorder when that family member is covered under this Plan. Family therapy will be allowed regardless of the number of family members attending the family therapy session.

The Plan will not provide coverage for:

**(a)** Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs, except where expressly covered under another provision or Excellus BlueCross BlueShield medical policies; or

**(b)** Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by a governmental agency.

**Substance Use Disorders.** The Plan will provide coverage for care, supplies and treatment of Substance Use Disorders for services by a certified Substance Use Disorder Facility (freestanding agency or Facility or a Hospital center) for inpatient or outpatient care. The Plan shall comply with federal parity requirements.

**(1)** **Inpatient Treatment.** Coverage is provided for inpatient services for the diagnosis and treatment of Substance Use Disorders comparable to other similar Hospital benefits. This includes coverage for detoxification and rehabilitation services as a consequence of a Substance Use Disorder. Coverage is limited to Facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those Facilities that are licensed or certified by a similar state agency. In the absence of a similarly licensed or certified Facility or state agency, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization as alcoholism, substance abuse or chemical dependence treatment programs and recognized by the Claims Administrator.

The Plan also provides coverage for the diagnosis and treatment of Substance Use Disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed or certified by a similar state agency. In the absence of a similarly licensed or certified Facility or state agency, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization as alcoholism, substance abuse or chemical dependence treatment programs and recognized by the Claims Administrator.

Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

**(2)** **Outpatient Treatment.** Covered charges for outpatient care, supplies and treatment of Substance Use Disorders, including intensive outpatient program treatment, partial hospitalization and methadone treatment. Coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency. In the absence of a similarly licensed or certified Facility or state agency, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization as alcoholism, substance abuse or chemical dependence treatment programs and recognized by the Claims Administrator. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic

medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

Except as otherwise excluded under this Plan, family counseling will be allowed for a family member of the immediate family of a person diagnosed with a Substance Use Disorder when that family member is covered under this Plan. Family therapy will be allowed regardless of the number of family members attending the family therapy session.

Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

**Skilled Nursing Facility (SNF) Care/Rehabilitation Facility.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if the Claims Administrator determines that hospitalization would otherwise be required for the care of your condition, Illness or Injury.

The benefit for a Covered Person's care in these Facilities is limited to 180 days per admission. An admission (or series of admissions) that is separated by more than 90 consecutive days is considered to be a separate admission.

Charges for a private room will also be covered if a private room is deemed to be Medically Necessary.

**Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. In addition, coverage will only be provided for home care visits given by a certified Home Health Care Agency or licensed home care services agency. The Plan will provide coverage for Home Health Care Services and Supplies only if all of the following conditions are met: (a) a treatment plan is established and approved in writing by your physician and reviewed after every 20 visits; (b) you apply to the home care provider through your physician supporting evidence of your need and eligibility for the care; and (c) the home care is related to an Injury or Sickness for which you were hospitalized or for which you would have been hospitalized or confined in a nursing facility. The care must be at a skilled or acute level of care.

**Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six (6) months, and palliative care (pain control and symptoms relief) rather than curative care is considered most appropriate.

The Plan will provide coverage for the following services:

**(1)** Bed patient either in a designated Hospice Unit or in a regular Hospital bed;

**(2)** Home care and outpatient services provided by the Hospice Agency including intermittent nursing by a registered nurse or licensed practical nurse or by a home health aide;

**(3)** Physical, occupational, speech, and respiratory therapy;

**(4)** Medical social services and nutritional services;

**(5)** Laboratory, x-ray, chemotherapy, and radiation therapy when needed to control symptoms;

**(6)** Medical supplies and drugs and medications considered approved for the patient's condition under the U.S. Pharmacopoeia and/or National Formulary. Benefits are not payable if the drugs or medications are of an Experimental and/or Investigational nature;

**(7)** Durable Medical Equipment; and

**(8)** Bereavement counseling for the family, limited to five (5) visits per family provided at any time before or following the Covered Person’s death.

During this period of acceptance, all the patient's medical services related to the terminal illness must be provided by or obtained through the Hospice Agency. All services must be billed by the Hospice Agency. If services are not available under the Hospice Agency, benefits may be payable for Covered Services and Supplies under other provisions of this Plan.

**Urgent Care Facility**. The Plan covers Covered Services and Supplies provided by a legally operated freestanding emergency clinic or center for minor outpatient emergency medical care or emergency minor surgery. An outpatient Hospital emergency room does not qualify as an Urgent Care Facility.

## MEDICAL/SURGICAL SERVICES AND SUPPLIES

See the **Medical Necessity and Preauthorization** section of this booklet for details on which services must be preauthorized by your In-Network Provider or should be preauthorized by you. For additional information on care or treatment after hours, emergency services, or on how to make a complaint, please call the customer service number listed on your identification care or visit https://hr.syr.edu/benefits/health-benefits/medical.

### Surgical Charge Benefits

This benefit applies when a surgical charge is incurred for a surgical procedure that is performed as the result of a Covered Person's Injury or Sickness and while that person is covered for this benefit.

It may be the fee of the surgeon, the assistant surgeon or the anesthesiologist. Care and treatment for voluntary surgical sterilizations are covered.

If multiple surgical procedures are performed during the same operative session, the following rules apply. In these rules, the term “primary procedure” means the most expensive procedure, i.e., the procedure with the highest Allowed Charge. The term “secondary procedure” means any procedure other than the primary procedure.

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

**(1)** If bilateral or multiple surgical procedures are performed through the same incision, benefits will be determined based on the Allowed Charge for the primary procedures; plus 50% of the Allowed Charge for each additional procedure performed in the same area of the body or through the same incision.

Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures. Examples of incidental procedures are: an appendectomy; lysis of adhesions; splenectomy without separate pathology; biopsies of lymph nodes, liver, omentum or other organs; hernia through the same incision (umbilical, ventral, internal inguinal); secondary organs and en bloc incisions; tube enterostomies for decompression; and vasectomy accompanying prostatectomy.

**(2)** If multiple unrelated surgical procedures are performed during the same operative session but through different incisions, the Plan will provide the following benefits: (a) the benefits described above for the primary procedure; plus (b) 50% of the amount otherwise payable for all other procedures.

### Assistant Surgeon

Charges for assistant surgeon services are covered for performance of the covered procedure.

### Anesthesia

Benefits are available for administration of general anesthesia for covered surgical procedures.

Coverage is limited to anesthesia administration by anesthesiologists and/or Certified Registered Nurse Anesthetists. The Plan will not pay charges for administration of anesthesia given by the surgeon, the assistant surgeon, or by a Hospital employee. Exception: Administration of anesthesia by a Dentist who performed the surgery is covered when the anesthesia is rendered during a covered oral surgical procedure.

The allowance for anesthesia includes the usual patient consultation before anesthesia and the usual care after surgery. Anesthesia administration expenses are not covered if the surgery is not covered by the Plan.

Coverage is also available for administration of anesthesia for non-surgical procedures, for example, covered electroshock therapy.

**Maternity**

Care and treatment of Pregnancy is covered the same as any other Sickness.

Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

If you choose to be discharged from the Hospital before the recommended time frames noted above, you are eligible for one (1) home health care visit by a qualified Home Health Care Agency. This visit is separate and does not apply to any visit limits set under any other home health care benefit. A home health care maternity visit must be requested within 48 hours of the time of delivery (96 hours in the case of cesarean delivery). The visit must be rendered within 24 hours of discharge, or of the time of the request, whichever is later. The visit should include parental education; assistance and training in breast or bottle feeding; and the performance of any necessary maternal and newborn clinical assessments. The charge for this visit is not subject to any applicable Coinsurance, Copayment or Deductible amounts.

In any case, group health plans may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are available for services by a physician or certified nurse midwife for childbirth (including home births), cesarean section, and other maternity care.

The payments for childbirth, cesarean section or termination of a Pregnancy will include the usual care given by a Provider before and after the obstetrical procedure (prenatal or postnatal care).

Please see Durable Medical Equipment for breast pump purchase/rental.

**Elective Sterilization**

Facility and other Provider charges for care and treatment related to voluntary surgical sterilizations are covered.

**Transgender Healthcare and Gender Identity Services**

The Plan will not limit coverage or impose additional cost sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual’s sex assigned at birth, gender identity, or gender otherwise recorded is different from the gender for which such health services are ordinarily available. In such cases, the Plan generally will rely on recommendations of the treating physician, Excellus Blue Cross Blue Shield medical policies, and applicable legal guidance to determine if a particular service is medically appropriate.

Transgender and gender identity services include:

(1) Medically Necessary gender confirming surgical services;

(2) Mental health care, including but not limited to, all forms of gender identity, gender expression, gender dysphoria, gender questioning, and/or related to all stages of transition;

(3) Medically Necessary hormone therapy; and/or

(4) Any other services as described in the Excellus BlueCross BlueShield medical policies surrounding this coverage.

**Reconstructive Surgery**

The Plan covers care required to significantly restore tissue damaged by an Illness or Injury or for reconstructive surgery that is incidental to or follows surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive surgery because of a congenital disease or anomaly that has resulted in a functional defect.

**NOTICE REGARDING THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998**

Federal law requires group health plans that provide medical and surgical benefits for mastectomies to provide coverage in connection with the mastectomy (in the manner determined by the attending physician and the patient) for:

**(1)** reconstruction of the breast on which the mastectomy was performed,
**(2)** surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and
**(3)** treatment of physical complications at all stages of mastectomy, including lymphedema.

Group health plans and health insurers may not deny eligibility to enroll, renew, or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. In addition, the law prohibits penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care, or providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with the law.

The above-described coverage required by applicable law may only be subject to the Cost-Sharing provisions that apply to similar benefits.

If you have any questions about this coverage, please contact your Plan Administrator at 315.443.4042, or the Claims Administrator at the telephone number listed on your identification card.

**Transplants - Organ/Autologous Bone Marrow/Stem Cell Transplants**

Benefits are available for expenses related to non-Experimental and/or Investigational organ or tissue transplants the same as any other Illness. Unless otherwise specifically included, transplants are considered Experimental and/or Investigational unless specifically included for Medicare coverage by the Centers for Medicare & Medicaid Services (CMS).

Transplants must meet the Medicare criteria for coverage to be considered for coverage under this Plan. Benefits are not available for expenses related to transplants that have not been approved by CMS or that fail to meet CMS criteria for coverage. Plan coverage for Hospitals will be based on the same criteria set forth by CMS criteria. If CMS restricts coverage for a transplant to approved Hospitals only, then this Plan will only cover those transplants when rendered in the approved Hospital.

Benefits will be available for the following in connection with a covered transplant.

**(1)** **Recipient Expenses**. Coverage includes all Plan benefits available for care and treatment related to covered organ transplants including, but not limited to: pre-transplant care including evaluation, diagnostic tests and x-rays by the transplant Hospital; procurement/tissue harvest and preparation; recipient's transplant surgery and recovery; and post discharge care.

**(2)** **Donor Expenses.**

**(a)** Coverage includes expenses incurred by the live donor(s) for expenses related to procurement of an organ and for transportation of the organ(s) to the extent such charges are not reimbursed by the donor's plan.

**(b)** If you or your Qualifying Dependent acts as a donor, the donor expenses ***will not*** be covered by this Plan unless the recipient is a Covered Person under the Plan. Then, donor expenses will be considered as part of the organ recipient's claim.

Donor charges and donor search charges will be deemed to be incurred on the date of the transplant even if the services were rendered before such date. No benefits will be paid for pre-transplant testing in connection with a search for a donor who is not a family member.

**(3)** **Autologous Bone Marrow/Stem Cell.** Courses of treatment involving high dose chemotherapy or radiotherapy and autologous bone marrow, stem cell rescue, or other hematopoietic support procedures are not covered as organ and tissue transplants, except for the following (and only then for candidates who meet established

national health and age standards): acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, and neuroblastoma as allowed under CMS guidelines. If CMS guidelines change, adding or deleting coverage under Medicare, this Plan will include or exclude those procedures. Recipient and donor expenses for covered procedures will be considered on the same basis as organ transplants shown above.

**In-Hospital/Facility Physician's Care Benefits**

This benefit applies when a medical charge is incurred for the inpatient care of a Covered Person's Injury or Sickness during a covered confinement in a Facility.

However, a medical charge will not include:

**(1)** a charge for care not rendered in the presence of a physician; or

**(2)** a charge for care received on the day of or during the time of recovery from a surgical procedure or maternity services; however, this limit does not apply if the care is for an unrelated condition.

Benefits are limited to one (1) visit per day per condition during a covered admission. See the **Appendices - Schedule of Benefits** for limitations for each type of admission to a covered facility.

**Specialist Consultations**

**(1)** **Inpatient Consultations.** Coverage is limited to one (1) inpatient consultation per specialty for each inpatient stay. If the consultant takes over the management (treatment) of the condition, consultation benefits are not payable nor are subsequent management visits considered to be consultations.

**(2)** **Outpatient/Office Consultations.** Coverage for outpatient or office consultations is provided for as many specialty opinions requested by the attending physician.

**(3)** **Second Opinion Consultation.** Benefits are available for patient-requested second opinion consultations before proceeding with a covered procedure or treatment. The second opinion consultation must be given by a board-certified physician specialist whose specialty is appropriate to consider the need for the proposed procedure.

Whether or not the second (or third) opinion agrees that the procedure is necessary, the Plan will cover the second (or third) opinion consultation. It is the patient's decision whether to undergo the procedure.

**Physician Care (Outpatient/Office)**

The professional services of a Professional Provider for evaluation and management, or therapeutic medical visits in an office, outpatient Hospital clinic, home, or elsewhere. Services must be given and billed by covered healthcare Providers.

Other sections of this booklet may describe physician care for specific benefits in greater detail.

**Allergy Treatment** to include evaluation and allergy testing, injections, and serum.

**Foot Care and Podiatry Services**

Benefits are available for treatment related to care of the feet. Coverage includes services or supplies rendered and billed by licensed physicians (medical doctors, osteopaths or podiatrists) for conditions of the feet.

Charges for routine foot care are only covered for patients with severe systemic disorders, such as diabetes and peripheral-vascular disease. See also Orthotics. Services or supplies for orthopedic shoes or shoe inserts are not covered (please refer to **Plan Exclusions**).

**Diagnostic Testing, X-ray and Lab Charge Benefits**

Diagnostic testing, x-ray and laboratory charges are for x-rays, machine, and laboratory tests. Benefits are provided for

diagnostic services required in the diagnosis of a condition due to Injury or Sickness consisting of:

**(1)** Diagnostic radiology, ultrasound, nuclear medicine, and necessary supplies.

**(2)** Diagnostic medical services such as cardiographic and encephalographic testing, radioisotopic studies and other procedures which may be approved when performed and billed by a physician.

**(3)** Pathology tests (laboratory tests) when performed, billed for or ordered by a physician.

Coverage includes separate physician's charges for interpretations of covered diagnostic services given by a Hospital, Skilled Nursing Facility or other covered Facility.

Charges for the following will not be included in this section:

**(1)** premarital exams;

**(2)** routine physical exams;

**(3)** x-ray therapy or chemotherapy; or

**(4)** exams performed as part of dental work, eye tests or fitting of lenses for the eye.

**Dialysis**

Benefits are available for service or supplies related to outpatient dialysis procedures given and billed by Professional Providers or Medicare-certified dialysis centers. Home self-dialysis is also covered when ordered by the attending physician and home setting found medically appropriate according to Plan provisions. If you are on home dialysis, coverage includes related laboratory tests and consumable or disposable supplies needed for the dialysis. Equipment is also covered. Benefits are not payable for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, or air conditioning, or for convenience or comfort items.

A person receiving kidney dialysis could be eligible for Medicare due to End Stage Renal Disease (ESRD); see **Medicare Integration When Medicare Is Primary** for details on this Plan's coordination of benefits with Medicare.

**Note:** Persons of any age who are diagnosed with end stage renal disease (ESRD) should contact the Social Security Office for Medicare eligibility and enrollment details. If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period). See the definition of Allowed Charges shown later in this document for benefit payment details under the Plan. Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

**In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the Virus that causes COVID-19**

Effective as of March 13, 2020, during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), or until such other date determined to be appropriate by the Employer, the Plan will provide coverage for an in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 that—

**(1)** is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb–3);

**(2)** the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under

such section within a reasonable timeframe;

**(3)** is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID–19; or

**(4)** other tests that the Secretary determines appropriate in guidance.

Effective for tests obtained on or after January 15, 2022 but before May 12, 2023, the Plan will also provide coverage for COVID-19 at home over-the-counter (OTC) tests, regardless of whether or not a Provider ordered, administered or prescribed such tests. COVID-19 OTC tests are covered under the Prescription Drug Benefits section of this booklet and not this section. Please refer to the Prescription Drug Benefits section for coverage details, including any limits and/or exclusions. Effective as of May 12, 2023, the Plan does not provide coverage for COVID-19 OTC tests.

In addition to the above, the Plan will provide coverage for any items and services provided during an office visit (including telehealth, see note below), urgent care center visit, or emergency room visit that relates to the furnishing or administration of the test or to the evaluation of the individual for purposes of determining the need for the test; and results in an order for or administration of such test. Such coverage will not be subject to any cost-sharing, prior authorization or medical management requirements under the Plan. Other services that you may receive during such a visit that are not related to determining the need for a test or administration of a test, will be subject to the normal Plan cost-sharing, prior authorization and medical management requirements. As explained in the Telehealth section of the booklet, providers that participate in MDLive are not authorized to order tests for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19.

For tests obtained prior to January 15, 2022, if the Covered Person uses a test that requires self-administered collection of a testing sample (a “home test kit”), the Plan will provide coverage as described above in the form of a reimbursement to the Covered Person, provided that the Covered Person’s claim submission to the Claims Administrator includes all of the following:

**(1)** The test be an approved test, recommended by the Covered Person’s attending provider.

**(2)** The Covered Person provides evidence of the cost of the test (i.e. receipt of payment). The Covered Person must provide evidence including the appropriate diagnosis code and CPT code as provided by the attending provider, and that the Covered Person’s attending provider determined that each test for which the Covered Person is seeking reimbursement was medically appropriate.

**(3)** The Covered Person needs to provide the referring provider’s name and NPI or TIN.

Effective as of May 12, 2023, the Plan will provide coverage for an in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 that—

**(1)** is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb–3);

**(2)** the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

**(3)** is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID–19; or

**(4)** other tests that the Secretary determines appropriate in guidance.

In addition to the above, the Plan will provide coverage for any items and services provided during an office visit (including telehealth, see note below), urgent care center visit, or emergency room visit that relates to the furnishing or administration

of the test or to the evaluation of the individual for purposes of determining the need for the test; and results in an order for or administration of such test. Such coverage will be subject to the normal Plan cost-sharing, prior authorization and medical management requirements. As explained in the Telehealth section of the booklet, providers that participate in MDLive are not authorized to order tests for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19.

**Radiation/Chemotherapy Benefits**

This benefit applies when a radiation or chemotherapy charge is incurred for therapy that is performed as part of the care of a Covered Person's Sickness and while the person is covered for this benefit.

**Radiation therapy charge and limits**

A radiation charge is the Allowed Charge of a physician for x-ray, radium or radiotherapy treatment, including the cost of the radioactive matter.

Radiation charges will not include charges for diagnostic or cosmetic procedures.

**Chemotherapy charges and limits**

A chemotherapy charge is the Allowed Charge of a physician for chemotherapy.

The type of drug for which benefits are provided is limited to anticancer drugs and hormone therapy that are not in an Experimental and/or Investigational stage to include antineoplastic agents (such as anticancer drugs) as well as agents used to destroy microorganisms (such as antibiotic drugs).

**IV Therapy/Infusion Services**

Ambulatory or home intravenous services ordered by a physician to include intravenous medications, blood, hydration and electrolyte replacement, and total parenteral nutrition.

**Private Duty Nursing Care**

The private duty nursing care by a licensed nurse (RN, LPN or Licensed Vocational Nurse (LVN)). Covered Services and Supplies will be included to this extent:

**(1)** **Inpatient Nursing Care.** Charges are covered only when care is not Custodial Care and so intense that the Hospital or Skilled Nursing Facility staff could not be expected to render such care. Shortage of general nursing staff does not establish Medical Necessity for private duty nurses.

**(2)** **Outpatient Nursing Care.** Charges are covered only when care is not Custodial Care. The charges covered for outpatient nursing care are those shown under Home Health Care Services and Supplies or billed by a certified or licensed visiting nurse agency or by a state or county visiting nurse service for professional nurse services.

A licensed practical nurse will be allowed if the doctor certifies that a registered nurse is unavailable for an approved plan of skilled nursing care.

Skilled nursing must be needed to manage the care of acutely ill patients and must not be ordered primarily at the request of a family or household member.

**Rehabilitation Therapy**

Benefit coverage is described in the **Appendices - Schedule of Benefits** for:

**(1)** **Physical Therapy** by a licensed physical therapist. The therapy must be in accord with a physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. If the patient reaches maximum potential for significant and measurable improved

function, or if care is found by the Claims Administrator to be Maintenance Care, benefits will no longer be payable.

**(2)** **Speech Therapy** by a licensed speech therapist. Therapy must be ordered by a physician and follow either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (b) an Injury; or (c) a Sickness. If the patient reaches maximum potential for improved, or age appropriate function benefits will no longer be payable.

**(3)** **Occupational Therapy** by a licensed occupational therapist. Therapy must be ordered by a physician, result from an Injury or Sickness and improve a body function. Covered services do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

Please refer to **Plan Exclusions** for information on therapy services that can be covered under a municipality's early intervention program or that can be provided by a school.

**(4)** **Cardiac Rehabilitation** for outpatient telemetric monitoring during exercise for cardiac rehabilitation rendered at a Hospital or free-standing cardiac rehabilitation center. Services must be rendered by a physician, or by a professional nurse trained in cardiac rehabilitation. Services must be ordered by the attending doctor and due to certain medical conditions, such as post valvular or congenital heart surgery; post heart transplants; dilated cardiomyopathy; post myocardial infarction; post bypass surgery or angioplasty; or stable angina. The plan of care must be approved for benefits by the Claims Administrator.

This benefit is limited to expenses for telemetric monitored exercise for cardiac rehabilitation only. No other exercise programs are covered. Coverage is limited to a frequency of three (3) times per week and up to a maximum of 18 consecutive weeks for an approved plan of care. Related testing procedures such as stress tests will be considered separately as diagnostic testing. Related physician exams and evaluations will be considered separately as physician visits. Separate charges for use of exercise equipment are not covered.

**(5)** **Inhalation or Respiratory Therapy** for short-term outpatient inhalation therapy when ordered by the attending physician for therapy services given by certified licensed respiratory therapists or other qualified Providers. Custodial Care or Maintenance Care is not covered.

**(6)** **Pulmonary Rehabilitation** is covered when services are performed by a pulmonary rehabilitation program approved by the Claims Administrator. In determining whether services are Medically Necessary, the Claims Administrator will apply the medical necessity criteria for pulmonary rehabilitation of the American Association of Cardiovascular and Pulmonary Rehabilitation for patients with chronic pulmonary disease. The plan of care must be approved for benefits by the Claims Administrator prior to the start of treatment.

Coverage is limited to a maximum of 36 visits per Covered Person per Lifetime for an approved plan of care. Related testing procedures will be considered separately as diagnostic testing. Related physician exams and evaluations will be considered separately as physician visits.

**Durable Medical Equipment**

Rental of durable medical or surgical equipment when ordered by the attending physician or Professional Provider. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, as determined by the Claims Administrator.

The equipment must be the kind that is generally used for a medical purpose, as opposed to a comfort or convenience purpose.

Durable medical equipment is equipment that can withstand repeated use; can normally be rented and reused by successive patients; is primarily and customarily used to serve a medical purpose; generally, is not useful to a person in the absence of illness or injury; and is appropriate for use in a person's home. Examples of covered equipment include, but are not limited to: crutches, wheelchairs (the Plan will not pay for a motor-driven wheelchair unless the Claims Administrator determines it is appropriate), a special hospital type bed, or a home dialysis unit.

The necessary repairs and maintenance of purchased equipment may be allowed, unless covered by a warranty or purchase agreement. Charges for delivery are not covered.

No coverage is provided for the cost of rental, purchase, repair or maintenance due to misuse, loss, natural disaster or theft, unless approved in advance by the Claims Administrator. The Plan will not pay for the additional cost of deluxe equipment unless the Claims Administrator determines it is appropriate.

Breast pumps are limited to one (1) rental or purchase per pregnancy.

**Prosthetics**

The Plan will provide coverage for the initial purchase, fitting and repair of fitted Prosthetic devices prescribed by a Professional Provider necessary to correct a condition caused by Injury or Sickness.

The Plan will cover replacements for the following: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Your physician must order the Prosthetic device for your condition before its purchase. Although the Claims Administrator requires that a physician prescribe the device, this does not mean that the Claims Administrator will automatically determine you need it. The Plan will only provide benefits for a Prosthetic device that the Claims Administrator determines can adequately meet the needs of your condition at the least cost.

The necessary repairs and maintenance of purchased equipment may be allowed, unless covered by a warranty or purchase agreement. No coverage is provided for: the purchase or replacement of any Biomechanical Prosthetic Device, routine maintenance and charges for delivery; the cost of rental, purchase, repair or maintenance of Prosthetic devices because of misuse, loss, natural disaster or theft unless approved in advance by the Claims Administrator.

**Wigs**

Charges associated with the initial purchase of a wig for hair loss due to cancer treatments, burns, or systemic disease. Wigs are limited to $500 per Lifetime and are not an Essential Health Benefit.

**Orthotics**

The initial purchase, fitting and repair of Orthotic appliances such as braces, splints or other appliances which are required for support for an injured or malformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Foot Orthotics are also covered.

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

**Oxygen**

Oxygen and the related equipment and supplies for its administration when found appropriate for self-care home use.

**Medical Supplies (Home Use)**

Benefits are available for certain disposable medical and surgical supplies used in the home when ordered by the attending physician. Items such as gauze pads, swabs, alcohol, deodorizers, and adhesive tape are not covered. Coverage is limited to the following items:

**(1)** Ostomy bags and supplies required for their use.

**(2)** Catheters and supplies required for their use.

**(3)** Extensive surgical dressings necessary for conditions such as cancer, diabetic ulcers and burns.

Not included in this benefit are: supplies that the Claims Administrator considers to be purchased primarily for comfort or convenience; delivery and/or handling charges.

**Dental Care**

Injury to or care of mouth, teeth and gums. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be covered only if that care is for the following oral procedures:

**(1)** Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

**(2)** Excision of benign bony growths of the jaw and hard palate.

**(3)** External incision and drainage of cellulitis.

**(4)** Incision of sensory sinuses, salivary glands or ducts.

**(5)** Emergency repair due to Injury to Sound Natural Teeth within twelve months of the Injury.

**(6)** Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth within twelve months of the Injury.

**(7)** Dental treatment due to a congenital disease or anomaly. For purposes of this dental care section only, the term "congenital" means that the disease or anomaly is present at birth and its symptoms or characteristics are evident and observable at birth.

**(8)** Reduction of dislocations and excision of Temporomandibular Joints (TMJs) due to a medical disorder.

Hospital or other Facility charges for dental-related services that require a Hospital inpatient or outpatient admission due to an underlying medical condition.

No charge will be covered for dental and oral surgical procedures involving dental care of the teeth including fillings, x-rays, and correction of impactions; orthodontic treatment; periodontal disease; dental implants; jaw expanders; crowns; caps; and preparing the mouth for the fitting of or continued use of dentures.

Dentures and other dental devices may be covered as Prosthetics if needed due to an accidental Injury to Sound Natural Teeth.

**Infertility Treatment**

Infertility treatment is limited to $20,000 per Lifetime and is not an Essential Health Benefit. Prescription drugs to treat Infertility are not covered under this section of the booklet. They are covered under the **Prescription Drug Benefits** section of the booklet and are subject to a separate $20,000 per Lifetime limit. Please refer to the **Prescription Drug Benefits** section of this booklet for additional details.

**(1)** Expenses related to the diagnosis and treatment to correct an underlying medical condition that results in Infertility are covered separately as any other Illness to include surgical or medical procedures and non-Experimental and/or non-Investigational drug therapy to correct malformation, disease, or dysfunction resulting in Infertility.

**(2)** Basic care for the diagnosis of Infertility for any Covered Person is covered as part of a physician's overall plan of care and limited to expenses for diagnostic tests and procedures necessary to determine Infertility and necessary in connection with any treatments (including, but not limited to, initial evaluation; laboratory

evaluation; evaluation of ovulatory function; hysterosalpingogram, endometrial biopsy, sono-hystogram, post-coital tests, testis biopsy, semen analysis, blood tests, ultrasound; and medically appropriate treatment of ovulatory dysfunction).

**(3)** If the basic infertility services described in (2) above do not result in increased fertility, coverage for the following comprehensive infertility services will be provided:

(a) Ovulation induction and monitoring;
(b) Pelvic ultra sound;
(c) Artificial insemination;
(d) Hysteroscopy;
(e) Laparoscopy; and
(f) Laparotomy.

The following are excluded:

(a) Procedures intended to facilitate a pregnancy to include in vitro fertilization, gamete intrafallopian transfers (GIFT), or zygote intrafallopian transfers (ZIFT);
(b) Costs for an ovum donor or donor sperm;
(c) Sperm storage costs;
(d) Cryopreservation and storage of embryos;
(e) Ovulation predictor kits;
(f) Reversal of elective sterilizations;
(g) Cloning;
(h) Services or procedures that are deemed to be Experimental and/or Investigational; and
(i) Costs for and relating to surrogate motherhood (maternity services are covered for Covered Persons acting as surrogate mothers).

A Covered Person must be considered an appropriate candidate for infertility treatment, as determined in accordance with the guidelines established by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine. Covered Persons must be between the ages of 21 and 44 (inclusive) in order to be considered an appropriate candidate for infertility treatment.

All infertility services (basic or comprehensive) must be provided by providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

**TMJ Syndrome**

Services for care and treatment of Temporomandibular Joint (TMJ) syndrome which was the result of a medical disorder. Dental-related conditions are not covered.

**Contact Lenses/Eyeglasses**

Initial contact lenses or glasses required following surgery for certain diagnostic medical conditions. Routine conditions, such as myopia, hyperopia/hypermetropia, presbyopia and astigmatism are not covered. No other eyeglasses, contact lens or visual aids, or related exams are covered under this benefit. The benefit is limited to one (1) pair every 24-consecutive month period.

**Nutritional Therapy**

Nutritional therapy with a registered or certified dietician; benefits are limited to eight (8) visits per Calendar Year with a registered or certified dietician. This eight (8) visit limit does not apply when nutritional therapy is necessary for the treatment of a Mental Health Disorder or Substance Use Disorder. Diabetic education is covered separately.

**Diabetic Supplies, Equipment and Education**

The following supplies and equipment are covered for the treatment of a diabetic condition when such supplies are ordered

or recommended by a physician:

**(1)** Blood glucose monitors and blood glucose monitors for the visually impaired;

**(2)** Test strips for glucose monitors, visual reading and urine testing;

**(3)** Injection aids;

**(4)** Cartridges for the legally blind;

**(5)** Syringes;

**(6)** Data management systems;

**(7)** Insulin pumps or insulin infusion devices (and accessories) when conventional injection therapy is found to be inadequate to treat the patient's condition;

**(8)** Alcohol swabs;

**(9)** Additional equipment and supplies as may be required by regulation of the New York State Commissioner of Health.

Items such as adhesive tape and gauze are not covered.

Insulin and oral agents to control blood glucose are covered under the separate prescription drug benefit.

Diabetic self-management education and education relating to diet may be covered for a Covered Person with a diabetic condition. Self-management education or diet instruction will only be covered when the patient is initially diagnosed with diabetes or when a physician diagnoses a significant change in the patient's symptoms or condition that requires changes in the patient's self- management. Additional education or refresher education is also covered if deemed appropriate.

These educational services will be covered when provided by:

**(1)** A physician, nurse practitioner, or his/her staff during an office visit for diabetes diagnosis or treatment. When the self-management service education is provided during an office visit, the benefit payment for the office visit will include payment for the self-management education;

**(2)** A certified diabetes nurse educator, certified nutritionist or certified and registered dietician when referred by a physician or nurse practitioner; or

**(3)** A Professional Provider as described above may be covered for services rendered in the patient's home.

**Chiropractic Care**

Spinal manipulation/chiropractic services by a licensed doctor of chiropractic (DC) for the detection or correction of the structural imbalance or subluxation in the human body to remove nerve interference resulting from, or related to distortion, misalignment or subluxation of or in the vertebral column. The therapeutic care must be directed at functional improvement (active treatment). Benefits will not be paid for any Maintenance Care or care to prevent worsening.

**Acupuncture**

Acupuncture is covered when used for palliative pain relief to include office visits, treatment, and related services and supplies rendered by a certified acupuncturist.

**Vision Therapy (Orthoptics)**

Charges for orthoptics (eye muscle exercises).

**Food Supplements**

Limited coverage is available for certain food supplements, nutrients or food products when ordered, in writing, by a physician, or other Provider legally authorized to prescribe drugs. Benefits will not be paid for normal products used in the dietary management of any disorders. Plan coverage is limited to the following:

**(1)** Aminoacidopathies Formula. Certain nutritional supplements (formulas) are covered for the therapeutic treatment of the following aminoacidopathies (disorders that prevent the body from properly digesting amino acids): phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

**(2)** Enteral Formulas. The prescribing healthcare Provider must state in writing that the enteral formula is clearly Medically Necessary and has been proven effective as the disease-specific regimen for those individuals who are or will become malnourished or who suffer from disorders, which left untreated, cause chronic disability, mental retardation or death. These specific diseases include, but are not limited to, aminoacidopathies, gastric motility disorders such as chronic intestinal pseudo-obstruction and multiple severe food allergies that if left untreated will cause malnourishment, chronic physical disability, mental retardation, or death.

**(3)** Modified Solid Food Products. Coverage is available for modified solid food products that are low protein, or which contain modified proteins for certain inherited diseases of amino acid and organic acid metabolism.

**Blood Services**

Blood, including blood and blood derivatives that are not donated or replaced, blood transfusions, and blood processing. Administration of these items is included.

Coverage also includes services related to blood donations, autologous (patient donates own blood) or directed (donation of blood by individual chosen by patient), when there is a scheduled surgery that customarily requires blood transfusions.

**Clinical Trials (In-Network Only)**

The Plan will only allow Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. The Plan will not cover the clinical trial. Please note: Out-of-Network Providers will be allowed if an In-Network Provider will not accept the patient.

Routine Patient Costs, Approved Clinical Trial and Qualified Individual are defined as follows:

**Approved Clinical Trial** - a Phase I-IV trial conducted for the prevention, detection, or treatment of cancer or other life-threatening conditions as follows:

**(1)** Federally funded or approved by the (a) National Institute of Health (NIH), (b) Centers for Disease Control, (c) Agency for Health Research and Quality, (d) Center for Medicare and Medicaid Services, (e) a cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense (DOD) or Department of Veterans Affairs (VA), (f) a qualified non-governmental research entity identified by NIH grant guidelines; or (g) a VA, DOD or Department of Energy if the study or investigation has been reviewed and approved through a system of peer review that Health and Human Services determines (1) to be comparable to the system of peer review of studies and investigations used by the NIH and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

**(2)** Study or trial conducted under FDA approved investigational new drug application;

**(3)** Drug trial exempt from FDA approved investigational new drug application;

**(4)** Or as amended by the federal Patient Protection and Affordable Care Act.

**Qualified Individual** is a Covered Person who is eligible to participate in an Approved Clinical Trial according to trial protocol with respect to the treatment of cancer or other life-threatening disease or condition, and either (i) the

referring Provider is a participating health care Provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

**Routine Patient Costs** include all items and services consistent with the coverage provided in this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine patient costs do not include the Experimental and/or Investigational item/device/service itself; items/services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

**Autism Spectrum Disorder.**

The Plan will provide coverage for the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist for the screening, diagnosis, and treatment of autism spectrum disorder:

**(1)** **Screening and Diagnosis.** Coverage will be provided for assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

**(2)** **Assistive Communication Devices.** Coverage will be provided for a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, coverage may be provided for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for a Covered Person who is 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. Coverage will also be provided for 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. The Claims Administrator will determine whether the device should be purchased or rented.

Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered; however, coverage will be provided for 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 Covered Person's current functional level. No coverage is provided for delivery or service charges or for routine maintenance or the additional cost of equipment or accessories.

**(3)** **Behavioral Health Treatment.** Counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual will be covered when provided by a licensed provider. Coverage for applied behavior analysis will also be covered when provided by an applied behavior analysis provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

**(4)** **Psychiatric and Psychological Care.** Coverage will be provided 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.** Coverage will be provided for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such 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 the Plan.

The Plan will not provide coverage for any services, supplies or treatment identified above that are provided by an individualized education plan or covered under a municipality's early intervention program mandated by law or that any school system is required to provide under any law; this applies even if the Covered Person, parent or guardian does not seek provision of such services or supplies through an early intervention program (EIP) or through a school system. Exception: The Plan will consider benefits for Covered Services and Supplies which exceed the recommendations of or which are not available through the EIP or a school system.

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).

**Biofeedback**

Charges for biofeedback are covered. Biofeedback is a method of treatment that uses electronic instrumentation intended to teach patients self-regulation of certain physiologic processes not normally considered to be under voluntary control. The most common forms of biofeedback involve the measurement of muscle tension, skin temperature, electrical conductance or resistance of the skin, brain waves and respiration.

**Telehealth**

Coverage will be provided for any Covered Services and Supplies delivered by a Provider using telehealth. Covered Services and Supplies delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Plan that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies (e.g. telephone consultations, e-mail consultations, online internet consultations, etc.) by a Provider to deliver Covered Services and Supplies to a Covered Person while that person's location is different than the Provider's location. Telehealth may be provided by any Provider that chooses to use Telehealth.

Coverage will also be provided for Telehealth between a Covered Person and providers that participate with MDLive. Not all In-Network Providers participate with MDLive. For a listing of providers that participate with MDLive, a Covered Person may check the participating provider directory by visiting www.mdlive.com or by contacting MDLive, toll free, at 866.692.5045 (TTY: 800.770.5531).

The Plan's normal Copayment, Deductible and/or Coinsurance requirements will apply to Covered Services and Supplies delivered using Telehealth, except for Telehealth related to the furnishing or administration of certain tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19. The Plan's coverage for those services is described in the section of this booklet titled "In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the Virus that causes COVID-19." As noted in that section of this booklet, MDLive providers are not authorized to order tests for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19. Effective as of May 12, 2023, the Plan's normal Copayment, Deductible and/or Coinsurance requirements will apply to Covered Services and Supplies delivered using Telehealth, including Telehealth related to the furnishing or administration of certain tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19.

Telehealth allows a Covered Person to connect with a Provider via video conference, telephone or e-mail for the purposes of diagnosis, consultation and treatment; just as would be provided during a face to face office visit. If your Provider utilizes Telehealth he/she will provide you with instructions on how to access that service. Telehealth, through MDLive; however, is an optional service provided under the Plan. To utilize this service, a Covered Person must register by calling MDLive, toll free at 866.692.5045, or by visiting www.mdlive.com. MDLive will ask for the Covered Person's name, the patient's name (if not calling for yourself), the primary Covered Person's and patient's date of birth and zip code.

Common examples of when to use Telehealth, include, but are not limited to the following:

**(1)** The Covered Person's primary care doctor is not available.

**(2)** The Covered Person is traveling and in need of medical care.

**(3)** During or after normal business hours, nights, weekends and holidays.

**(4)** To request (non-DEA controlled) prescriptions or refills. Telehealth providers prescribe drugs or medications only if the provider deems it is Medically Necessary.

******Telehealth should only be used for non-emergent situations. If you feel you are in an urgent or life-threatening situation and need immediate assistance, please go to the nearest emergency room******

If you have questions concerning Telehealth or the MDLive program, the available care or coverage, or your benefits, please contact the customer service telephone number on your identification care or MDLive at the telephone number or internet address listed above. In the unlikely event that the Telehealth provider or MDLive is unable to resolve your inquiry, you may, as with any medical service, follow the claim and appeal process that is described in the **Claim Procedures and Appeals - Medical** section of this booklet.

# DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

**Allowed Charge**

**SUBlue and SUPro**
The Allowed Charge for **SUBlue and SUPro** means the maximum amount the Plan will pay for the services or supplies covered under this Plan, before any applicable Copayment, Deductible and/or Coinsurance amounts are subtracted. The Allowed Charge is determined as follows:

The Allowed Charge for In-Network Providers will be the amount the Claims Administrator has negotiated with the In-Network Provider or the amount approved by another Blue Cross and/or Blue Shield plan (if applicable). However, when the In-Network Provider's charge is less than the amount the Claims Administrator has negotiated with the In-Network Provider, your Copayment, Deductible and/or Coinsurance amount will be based on the In-Network Provider's charge.

The Plan's payments to In-Network Providers may include financial incentives to help improve the quality of care and promote the delivery of covered services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific covered service provided to you. Your Cost-Sharing will not change based on any payments made to or received from In-Network Providers as part of the financial incentive program.

The Allowed Charge for Out-of-Network Providers will be determined as follows:

**Facilities in the Service Area.**
For Facilities in the Service Area, the Allowed Charge will be 150% of the Centers for Medicare and Medicaid Services Prospective Payment System (MMSPPS) amount unadjusted for geographic locality, or the Facility's charge, if less.

If there is no MMSPPS amount as described above, the Allowed Charge will be 75% of the Facility's charge.

**Facilities Outside the Service Area.**
For Facilities outside the Service Area, the Allowed Charge will be the lesser of: (a) 150% of the Centers for Medicare and Medicaid Services Prospective Payment System (MMSPPS) amount unadjusted for geographic locality, (b) the Facility's charge or (c) a Blue Cross Blue Shield host plan's rate.

If there is no MMSPPS amount as described above, the Allowed Charge will be the lesser of: (a) 75% of the Facility's charge or (b) a Blue Cross Blue Shield host plan's rate.

**For a Professional Provider or a Provider of Additional Health Services in the Service Area.**
For a Professional Provider or a Provider of Additional Health Services in the Service Area, the Allowed Charge will be 150% of the Centers for Medicare and Medicaid Services Provider fee schedule (CMS Fee Schedule), as applicable to the provider type, unadjusted for geographic locality, or the Professional Provider or a Provider of Additional Health Services' charge, if less.

If there is no CMS Fee Schedule amount as described above, the Allowed Charge will be 75% of the Professional Provider or a Provider of Additional Health Services' charge.

**For a Professional Provider or a Provider of Additional Health Services Outside the Service Area.**
For a Professional Provider or a Provider of Additional Health Services outside the Service Area, the Allowed Charge will be the lesser of: (a) 150% of the Centers for Medicare and Medicaid Services Provider fee schedule (CMS Fee Schedule), as applicable to the provider type, unadjusted for geographic locality, (b) the Professional Provider or a Provider of Additional Health Services' charge or (c) a Blue Cross Blue Shield host plan's rate.

If there is no CMS Fee Schedule amount as described above, the Allowed Charge will be the lesser of: (a) 75% of the Professional Provider or a Provider of Additional Health Services' charge or (b) a Blue Cross Blue Shield host plan's rate.

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

**Ground Ambulance.** The Allowed Charge for an Out-of-Network Provider for ambulance services for an Emergency Medical Condition will be the Out-of-Network Provider's charge.

**Services Subject to Surprise Bill Rules.** The Allowed Charge for services that are subject to the surprise bill rules for an Out-of-Network Provider will be the Recognized Amount (as defined in the Defined Terms section). Please refer to the section entitled "SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS" for a description of the services that are subject to the surprise bill rules.

**In Vitro Diagnostic Test for the Detection of SARS-CoV-2.** The Allowed Charge for an Out-of-Network Provider for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 is the Out-of-Network Provider's publicly listed price for such test, or such lower rate as the Claims Administrator may negotiate with the Out-of-Network Provider. Effective as of May 12, 2023, the Allowed Charge for an Out-of-Network Provider for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 is the same Allowed Charge that applies to all other Out-of-Network Providers for the same or similar services.

**The Out-of-Network Provider's actual charge may exceed the Plan's Allowed Charge. Except in certain cases (see "SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS" section above), you must pay the difference between the Allowed Charge and the Out-of-Network Provider's charge. Contact the Claims Administrator at the number on your ID card or visit the Claims Administrator's website for information on your financial responsibility when you receive services from an Out-of-Network Provider.**

The Plan reserves the right to pay an Out-of-Network Provider a lower rate (other than with respect to surprise bills) negotiated by the Claims Administrator.

**SUOrange**
The Allowed Charge for **SUOrange** means the maximum amount the Plan will pay for the services or supplies covered under this booklet, before any applicable Copayment, Deductible and/or Coinsurance amounts are subtracted. The Allowed Charge is determined as follows:

The Allowed Charge for In-Network Providers will be the amount the Plan has negotiated with the In-Network Provider or the amount approved by another Blue Cross and/or Blue Shield plan (if applicable). However, when the In-Network Provider's charge is less than the amount the Plan has negotiated with the In-Network Provider, your Copayment, Deductible and/or Coinsurance amount will be based on the In-Network Provider's charge.

**Ground Ambulance.** The Allowed Charge for an Out-of-Network Provider for ambulance services for an Emergency Medical Condition will be the Out-of-Network Provider's charge.

**Services Subject to Surprise Bill Rules.** The Allowed Charge for services that are subject to the surprise bill rules for an Out-of-Network Provider will be the Recognized Amount (as defined in the Defined Terms section). Please refer to the section entitled "SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS" for a description of the services that are subject to the surprise bill rules.

**In Vitro Diagnostic Test for the Detection of SARS-CoV-2.** The Allowed Charge for an Out-of-Network Provider for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 is the Out-of-Network Provider's publicly listed price for such test, or such lower rate as the Claims Administrator may negotiate with the Out-of-Network Provider. Effective as of May 12, 2023, the Allowed Charge for an Out-of-Network

Provider for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 is the same Allowed Charge that applies to all other Out-of-Network Providers for the same or similar services.

Except for Emergency Services, ambulance services for an Emergency Medical Condition, Covered Services and Supplies provided by an Out-of-Network Provider in an In-Network facility, and in vitro diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, the SUOrange option under the Plan does not provide coverage for Out-of-Network Providers. Effective as of May 12, 2023, the SUOrange option under the Plan does not provide coverage for in vitro diagnostic testing for the diagnosis of the virus that causes COVID-19 when rendered by an Out-of-Network Provider.

The Plan's benefits for Emergency Services, Ambulance Services and Covered Services and Supplies provided by Out-of-Network Providers in In-Network facilities are described in the "**SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS**" section above.

**When Medicare is Primary**
The Allowed Charge when Medicare is primary will be based on the following:

**(1)** If the Provider accepts Medicare assignment of benefits, the Allowed Charge will be the same fees allowed by Medicare.

**(2)** If the Provider does not accept Medicare assignment, the Allowed Charge will be based on the Allowed Charge for In-Network Providers or Out-of-Network Providers (as described above under **SUBlue, SUPro and SUOrange)** or the charges determined by Medicare limiting charge regulations, whichever is the lower charge.

According to Medicare regulations, a beneficiary cannot be billed the difference between the Medicare allowed amounts and the Provider's charges when that Provider accepts Medicare assignment. If a Provider does not accept assignment, a beneficiary cannot be billed for charges over the limiting charge established by Medicare for that service by that Provider. If a Provider completely opts-out of Medicare and requires a beneficiary to sign a private contract (as defined in Chapter 15, Section 40.7 of the Medicare Benefit Policy Manual) acknowledging that Medicare cannot be billed, the beneficiary may be billed the difference between the Allowed Charge and the Provider's charge in addition to any Cost-Sharing amounts due under the Plan.

**Ambulatory Surgical Center** is a licensed Facility that is used mainly for performing outpatient surgery, has a staff of physicians, has continuous physician and nursing care by registered nurses (RNs) and does not provide for overnight stays. It must be operated according to the applicable laws of the jurisdiction in which it is located, or accredited by the Joint Commission for the Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Care, or a national accreditation organization recognized by the Claims Administrator or approved by Medicare to render outpatient surgery services.

If the center is part of a Hospital, it will not be considered an Ambulatory Surgical Center.

**Biomechanical Prosthetic Device** is a Prosthetic device that utilizes a computer microchip, myoelectric technology or other similar technology to control movement or use.

**Birthing Center** means any independent health Facility, place, professional office or institution where births occur in a home-like atmosphere. This Facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the Facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a physician and either a registered nurse (RN) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

**Calendar Year** means January 1 through December 31 of the same year.

**Claims Administrator** means Excellus Health Plan, Inc., doing business as Excellus Blue Cross Blue Shield ("Excellus"), for medical claims, and administers claims for benefits under the Plan on behalf of the Employer and does not insure your benefits. The Claims Administrator provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims. Excellus is a nonprofit independent licensee of the Blue Cross Blue Shield Association. The Claims Administrator for prescription drug benefit claims is Optum Rx.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Coinsurance** - see the **Benefit Payments** subsection of the **Comprehensive Medical Benefits** section of this booklet.

**Copayment** - see the **Benefit Payments** subsection of the **Comprehensive Medical Benefits** section of this booklet.

**Cost-Sharing** means amounts you must pay for Covered Services and Supplies, expressed as Coinsurance, Copayments and/or Deductibles.

**Covered Person** is any Participant or Qualifying Dependent enrolled in benefits or coverage under the Plan. Individuals who are Qualified Beneficiaries who are enrolled in the Plan pursuant to COBRA are also considered Covered Persons.

**Covered Services and Supplies or Covered Service and Supply** mean those Medically Necessary services or supplies that are covered under this Plan.

**Custodial Care** is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

**Deductible** – see the **Benefit Payments** subsection of the **Comprehensive Medical Benefits** section of this booklet.

**Dentist** is a person who is properly trained and licensed to practice Dentistry and who is practicing within the scope of such license.

**Domestic Partner** means either an eligible same-sex domestic partner or an eligible opposite-sex domestic partner, according to the criteria described within the Syracuse University Medical Benefits Plan and the Syracuse University Retiree Medical Benefits Plan.

**Durable Medical Equipment** means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Deluxe equipment is not allowable when standard equipment is available and medically adequate for the reported condition.

Disposable supplies may be allowed if required to operate the medical equipment.

**Emergency Medical Condition** is a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect that the absence of immediate medical attention may result in placing the health of the person in serious jeopardy (including the health of a pregnant woman or her unborn child); serious impairment to bodily function; serious dysfunction of any organ or part.

**Emergency Services** means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA) or as would be required under such Section if such section applied to an independent freestanding emergency department) within the capability of the Hospital emergency department (or freestanding emergency department), including routine ancillary services to evaluate an Emergency Medical Condition and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital (or freestanding emergency department) and required under EMTALA (or as would be required under EMTALA if it applied to an independent freestanding emergency department) to stabilize the patient (regardless of the department of the hospital in which such further

examination or treatment is furnished). Emergency Services also includes certain post-stabilization services, unless the following conditions are met:

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

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

**(3)** The Provider satisfies any additional applicable state law requirements and any additional requirements provided in guidance issued by the Department of Health and Human Services.

**Employer** is Syracuse University.

**ERISA** is the Employee Retirement Income Security Act of 1974, as amended.

**Essential Health Benefits** means benefits as defined by the Secretary of the Department of Health and Human Services (HHS) as required by the Patient Protection and Affordable Care Act (PPACA). Benefits include the following essential benefit class categories:

**(1)** Ambulatory patient services;

**(2)** Emergency services;

**(3)** Hospitalization;

**(4)** Maternity and newborn care;

**(5)** Mental health and substance use disorder services, including behavioral health treatment;

**(6)** Prescription drugs;

**(7)** Rehabilitative and habilitative services and devices;

**(8)** Laboratory services;

**(9)** Preventive and wellness services and chronic disease management; and

**(10)** Pediatric services, including oral and vision care.

The determination of what benefits constitute an Essential Health Benefit under the Active Plan and Retiree Plan will be made in accordance with the benchmark plan for the state of Utah.

**Experimental and/or Investigational** means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Claims Administrator must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. The Claims Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Claims Administrator will be final and binding on the Plan.

The Claims Administrator will consider the following in making its decision:

**(1)** if the drug or device cannot be lawfully marketed without approval of the US Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

**(2)** if the drug, device, technology, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating Facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;

**(3)** if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; and

**(4)** if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating Facility or by another Facility studying substantially the same drug, device, medical treatment or procedure.

Prescription Drugs are considered Experimental and/or Investigational if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

If any of the entities used to determine the Experimental and/or Investigational status of a drug, device, supply, treatment or any other medical service reverses, modifies, or establishes its policy for such expenses, and makes such changes retroactive, the Plan will not make payment for related retroactive incurred expenses. The Plan will not seek refund for its previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

**Facility**. A Hospital; Ambulatory Surgical Center; Birthing Center; dialysis center; rehabilitation facility; Skilled Nursing Facility; hospice; Home Health Care Agency certified or licensed under Article 36 of the New York Public Health Law (or the comparable law of the state where the services are provided); institutional provider of mental health care that is a hospital as defined by subdivision ten of section 1.03 of the New York Mental Hygiene Law (or the comparable law of the state where the services are provided); a Substance Use Disorder Facility; or other provider certified under Article 28 of the New York Public Health Law (or the comparable law of the state where the services are provided); or an independent clinical laboratory.

**Final Adverse Benefit Determination.** When a claim is denied at the end of the Step Two Appeal process, the Plan's decision is known as a Final Adverse Benefit Determination.

**Home Health Care Agency** is a certified home health agency or a licensed home care services agency under Article 36 of the New York Public Health Law (or the comparable law of the state where the services are provided). If operating outside of New York State, the home health agency or home care services agency must be qualified by Medicare.

**Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (RN); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational, respiratory, and speech therapy; medical social services; medical supplies; and laboratory services by or on behalf of the Home Health Care Agency.

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

**Hospice Agency** is an organization that has an operating certificate issued by the New York State Department of Health. If Hospice Care Services and Supplies are provided outside of New York State, the hospice organization must have an

operating certificate issued under criteria similar to those used in New York by a state agency in the state where the Hospice Care Services and Supplies are provided, or it must be approved by Medicare.

**Hospice Care Services and Supplies** are those services provided through a Hospice Agency and covered under the terms of this Plan. Refer to the **Comprehensive Medical Benefits** section of this booklet for coverage details.

**Hospice Unit** is a Facility or separate Hospital unit that provides treatment by a Hospice Agency.

**Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association Healthcare Facilities Accreditation Program or a national accreditation organization recognized by the Claims Administrator; it is certified under Medicare as a Hospital; licensed pursuant to Article 28 of the Public Health Law of New York if located in New York or the comparable law of the state where it is located; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of physicians; and it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (RNs). None of the following are considered Hospitals: places primarily for nursing care; Skilled Nursing Facilities; convalescent homes or similar institutions; institutions primarily for Custodial Care, rest or as domiciles; health resorts, spas or sanitariums; infirmaries at schools, colleges or camps; places primarily for the treatment of substance use disorders, hospice care, or rehabilitation; or free standing Ambulatory Surgical Centers.

**Hospitalist** is a physician that assumes the care of a hospitalized patient and acts as a primary doctor while a patient is in a Hospital.

**Illness** means a bodily disorder, disease, physical Sickness or Mental Health Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

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

**Infertility** is the result of a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a Pregnancy to delivery. The duration of unprotected intercourse with failure to conceive should be about 12 months before an Infertility evaluation is undertaken, unless medical history, age, or physical findings dictate earlier evaluation and treatment.

**Injury means** a physical injury to the body caused by external means.

**In-Network Benefit(s)** apply when your care is rendered by an In-Network Provider. You may be responsible for meeting an annual Deductible and/or paying a Copayment and/or a Coinsurance amount on Covered Services and Supplies.

**In-Network Provider** means a Facility, Professional Provider or Provider of Additional Health Services who has a contract with the Claims Administrator or another Blue Cross and/or Blue Shield plan to provide health services to Covered Persons.

A list of In-Network Providers and their locations is available at www.excellusbcbs.com/syredu. You may also obtain a paper copy, upon request and free of charge, by contacting the Claims Administrator at the telephone number listed on your identification card. The list may be revised from time to time.

The In-Network Provider directory will give you the following information about Participating Providers:

(1) Name, address, and telephone number;
(2) Professional qualifications;
(3) Specialty;
(4) Medical school attended, residency completion, and Board certification (if applicable);
(5) Languages spoken; and
(6) Whether the In-Network Provider is accepting new patients.

You are only responsible for any In-Network Cost-Sharing that would apply to the Covered Service and Supplies, and you will not be responsible for paying for any Out-of-Network Provider charges that exceed your In-Network Provider Cost-Sharing, if you receive Covered Services and Supplies from a Provider who is not an In-Network Provider because you reasonably relied on incorrect information provided to you about whether the Provider was an In-Network Provider in the following situations:

(1) The Provider is listed as an In-Network Provider in the online provider directory;
(2) The paper provider directory listing the Provider as an In-Network Provider is incorrect as of the date of publication;
(3) You were given written notice that the Provider is an In-Network Provider in response to your telephone request for network status information about the Provider; or
(4) You are not provided with written notice within one business day of your telephone request for network status information.

**Licensed Clinical Social Worker** is a social worker licensed in the state in which they are practicing.

**Lifetime** is a word that appears in this Plan in reference to benefit maximums and limitations for Covered Services and Supplies. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

**Maintenance Care** is care rendered and directed at relieving discomfort or preserving function secondary to conditions where further enhancement of function cannot be demonstrated or expected. Care that cannot be reasonably expected to lessen the patient's disability enabling him or her to leave an institution. Maintenance Care does not imply the absence of symptoms nor does it imply such services are not necessary. It implies care rendered to maintain a function and prevent the condition from worsening.

**Medically Necessary (or Medical Necessity) –** see the **Medical Necessity and Preauthorization** section of this booklet.

**Medicare** is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Mental Health Disorder (or Mental Disorder)** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Health Disorder in the current edition of International Classification of Diseases, published by the US Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

**Morbid Obesity** as defined in accordance with the Claims Administrator's medical policy criteria.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments and/or benefits without determining fault in connection with accidents in an automobile or other vehicle, as mandated under the applicable law.

**Orthotic** is an external appliance or device intended to correct any defect in form or function of the human body. This does not include, for example, eyeglasses or contact lenses, hearing aids, wigs, corsets, apparel, orthopedic shoes or shoe inserts, or supportive devices for the feet.

**Out-of-Network Benefit(s)** apply when your care is rendered by an Out-of-Network Provider. When you receive Out-of-Network Benefits, you usually will incur higher out-of-pocket costs. You will be responsible for meeting an annual Deductible and/or paying for a Coinsurance and/or Copayment amount on most covered services, as well as paying any difference between the Allowed Charge and the Provider's charge. Special rules apply to determine Plan benefits for certain Covered Services and Supplies provided by Out-of-Network Providers. See the "**SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS**" section of this booklet.

**Out-of-Network Provider** is a Provider that does not have a contract with the Claims Administrator or another Blue Cross Blue Shield plan to provide services to Covered Persons**.** When you receive Out-of-Network Benefits, you will incur higher out-of-pocket expenses. In addition to any applicable Copayment, Coinsurance or Deductible you will **be** responsible for paying any difference between the Allowed Charge and the Provider's charge. Special rules apply to determine Plan

benefits for certain Covered Services and Supplies provided by Out-of-Network Providers. See the "**SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS**" section of this booklet.

**Out-of-Network Rate** means the amount determined by the Claims Administrator in accordance with the requirements of 29 CFR 2590.716--3.

**Out-of-Pocket Limit** is the most you pay during a Calendar Year in Cost-Sharing before the Plan begins to pay 100% of the Allowed Charge for Covered Services and Supplies. This limit never includes the amounts you pay that are in excess of the Allowed Charge **or** the cost of health care services not covered under the terms and conditions of the Plan.

**Partial Hospitalization** is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Health Disorder or Substance Use Disorder when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse. For a Mental Health Disorder, this program shall be administered in a Facility that has been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or is operated by the Office of Mental Health and, in other states, to similarly licensed or certified Facilities. For a Substance Use Disorder, this program shall be administered in a Facility in New York State that is certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or is licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency. In other states, in the absence of a similarly licensed or certified Facility or state agency, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator. Treatment lasts less than 24 hours, but more than four (4) hours, per day, and no charge is made for room and board.

**Participant** means an individual who satisfies the requirements specified in the summary plan description for the Plan to be considered a Participant. Review the relevant summary plan description for the Plan (the Syracuse University Medical Benefits Plan Summary Plan Description, the Summary Plan Description for the Syracuse University Retiree Medical Benefits Plan or the Summary Plan Description for the Syracuse University Retiree Prescription Drug Plan) for a full description of the requirements to be considered a Participant.

**PCP** see Primary Care Physician**.**

**Physician Extender** includes physician assistants (PAs), nurse midwives, nurse practitioners (NPs) and advanced practice nurses (APNs). These Providers are generally overseen by physicians and must be licensed and regulated by a state or federal agency and acting within the scope of his or her license.

**Plan** means (a) with respect to coverage under the Syracuse University Medical Benefits Plan, the Syracuse University Medical Benefits Plan as it may be amended from time to time, and (b) with respect to coverage under the Syracuse University Retiree Medical Benefits Plan and Syracuse University Retiree Prescription Drug Plan, the Syracuse University Retiree Medical Benefits Plan as it may be amended from time to time.

**Plan Administrator** means the Administrative Benefits Committee of Syracuse University.

**Plan Year** is the 12-month period beginning on July 1 and ending on June 30.

**Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

**Prescription Drug** means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed physician.

**Primary Care Physician (PCP)** means a physician who is licensed in the state in which they are rendering services as a family practitioner, general practitioner, internist, pediatrician, or obstetrician/gynecologist.

**Prosthetics** is the making and application of any artificial part that replaces all or part of a body part, organ or function lost or impaired as the result of disease or Injury. Examples include artificial arms, legs, and eyes; ostomy bags and supplies required for their use; and catheters. Prosthetic devices do not include, for example, eyeglasses or contact lenses, hearing aids, wigs, orthopedic shoes or inserts or supportive devices for the feet, regardless of Medical Necessity of those items.

Dentures or other devices used in connection with the teeth are also not covered unless required due to an accidental Injury to sound natural teeth or necessary due to a congenital disease or anomaly.

**Professional Provider** means a certified and licensed physician, Doctor of Osteopathy (DO), Doctor of Podiatry (DPM), Doctor of Chiropractic (DC), certified nurse anesthetist, Hospitalist, Physician Extender, certified psychiatric nurse, licensed professional counselor (for care of Mental Disorders), licensed physical therapist, certified, registered or Licensed Clinical Social Worker, Master of Social Work (MSW) for care of Mental Disorders, midwife, occupational therapist, physio-therapist, psychiatrist, psychologist (PhD), speech language pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

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

**Provider** means a Facility, Professional Provider or Provider of Additional Health Services.

**Pulmonary Rehabilitation** is an individualized therapeutic multidisciplinary program of care for patients with chronic respiratory disease who remain symptomatic or continue to have decreased function despite standard medical treatment. Pulmonary Rehabilitation's goals are to reduce symptoms, optimize functional status, increase participation, and to train patients to successfully manage their disease process, and improve the overall quality of life for patients with chronic respiratory disease.

**Qualifying Dependent** means an individual who has a relationship with a Participant that satisfies the requirements to be an "Eligible Spouse," "Eligible Domestic Partner," or "Eligible Dependent" as those terms are defined in the Syracuse University Benefits Eligibility Policy. Although employees of Drumlins are not "Benefits Eligible Employees" under the Syracuse University Benefits Eligibility Policy, an individual who has one of the defined relationships with a Drumlins employee who is a Participant will be a Qualifying Dependent.

**Recognized Amount** means the lesser of billed charges or the "qualifying payment amount". The "qualifying payment amount" is the amount determined by the Claims Administrator in accordance with the requirements of 29 CFR 2590.716--3.

**Service Area** is the geographic territory within which the Claims Administrator is licensed to use the Blue Cross and Blue Shield service marks. The Service Area consists of the following counties: Broome; Cayuga; Chemung; Chenango; Clinton; Cortland; Delaware; Essex; Franklin; Fulton; Hamilton; Herkimer; Jefferson; Lewis; Livingston; Madison; Monroe; Montgomery; Oneida; Onondaga; Ontario; Oswego; Otsego; St. Lawrence; Schuyler; Seneca; Steuben; Tioga; Tompkins; Wayne; and Yates counties.

**Sickness** is a person's Illness, disease or Pregnancy (including complications).

**Skilled Nursing Facility** is a facility that fully meets all of these tests:

**(1)** It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (RN) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

**(2)** Its services are provided for compensation and under the full-time supervision of a physician.

**(3)** It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

**(4)** It maintains a complete medical record on each patient.

**(5)** It has an effective utilization review plan.

**(6)** It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, the mentally disabled, Custodial or educational care or care of Mental Disorders.

**(7)** It is approved and licensed by Medicare.

**(8)** It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a national accreditation organization recognized by the Claims Administrator.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital, long-term acute care facility or any other similar nomenclature.

**Sound Natural Teeth** are natural teeth that are fully restored to function; or do not have any decay; or that are not more susceptible to Injury than virgin teeth; or do not have significant periodontal disease.

**Substance Use Disorder Facility** means an agency or freestanding facility or a Hospital center that is certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) for the treatment of Substance Use Disorder (drugs and alcohol). For services given outside New York, the facility must be certified by a state agency similar to the New York State OASAS. If a state does not have a certification regulation, the facility must be approved by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by the Claims Administrator for the treatment of Substance Use Disorder.

**Substance Use Disorder** is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine containing drinks.

**Temporomandibular Joint (TMJ)** syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

**Tricare** is the Department of Defense's health care program for members of the uniformed services, their families and survivors.

**Urgent Care Facility** means a medical facility that is open on an extended basis, is staffed by physicians to treat medical conditions not requiring inpatient or outpatient Hospital care, and which is not a physician’s office.

**You, Your, and Yours** throughout this booklet refers to you, the Participant, and your Qualifying Dependents and any COBRA Qualified Beneficiary. If other than individual coverage applies, then, in most cases, the word “you” also includes any family members, including Domestic Partners, who are covered under this Plan.

# PLAN EXCLUSIONS

For all Medical Benefits shown in the Appendices - Schedule of Benefits, a charge for the following is not covered:

**(1)** **Anesthesia.** Services or supplies for the administration of anesthesia for any surgery or treatment that is not covered by the Plan.

**(2)** **Automobile Insurance, No-Fault Auto Insurance** for which the Covered Person is eligible to receive benefits through mandatory no fault or fault automobile insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. This applies whether or not a claim is made for payment under that coverage. Benefits under this Plan will automatically be denied if the No-Fault Auto Insurance or other payer of motor vehicle liability coverage denies benefits due to its DWI or DUI exclusion, felony exclusions, as not Medically Necessary, or for late filing. Charges for services or supplies not paid by the no-fault coverage due to its deductible or maximum payment limits will be covered under this Plan to the extent Allowed Charges would have otherwise been payable by this Plan. Note: No-fault and motor vehicle liability coverage is considered another plan under the **Coordination of Benefits** provision of this Plan.

**(3)** **Cosmetic.** Services or supplies connected with elective cosmetic surgery or treatment. Reversal of elective, cosmetic surgery will not be covered unless found to be Medically Necessary according to Plan provisions. Exception: Care required to significantly restore tissue damaged by an Illness or Injury or for reconstructive surgery (as specified in **the Comprehensive Medical Benefits** section of this booklet) that is incidental to or follows surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive surgery because of a congenital disease or anomaly of a child who is a covered Qualifying Dependent that has resulted in a functional defect.

**(4)** **Counseling/Analysis/Support Groups.** Services or supplies primarily directed at raising the level of consciousness, social enhancement, counseling limited to everyday problems of living such as marriage counseling, family counseling, pastoral counseling; sex therapy, or support groups, except as approved by the Claims Administrator.

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

**(a)** The service or care would be covered under this Plan in the absence of a court order;
**(b)** All applicable procedures have been followed to authorize the service or care; and
**(c)** The Claims Administrator determines, in advance, that the service or care is Medically Necessary and covered under the terms of this Plan.

This exclusion also applies to any service or care (including evaluation, testing, and/or treatment) that an arbitrator, administrative tribunal, or a court orders in connection with litigation or other legal matters.

**(6)** **Custodial or Maintenance Care.** Services or supplies provided mainly as a rest cure, Maintenance Care or Custodial Care or domiciliary care consisting chiefly of room and board.

**(7)** **Dental Care.** Services or supplies related to care or treatment of the teeth, gums or alveolar process, such as dental caries (tooth decay), extractions whether simple or surgical, periodontics, bridges, crowns, orthodontia, implants, crowns, caps, or other services considered to be dental, rather than medical, in nature. Adjustments, services or supplies related to appliances for dental- related treatment of Temporomandibular Joint disorders (TMJ) or similar disorders.

**Exceptions:**

Charges by a Dentist or physician for care otherwise considered medical care (such as reduction of fractures of the jaw or facial bones, surgical correction of cleft lip, cleft palate, treatment of congenital disease or anomaly, removal of stones from salivary ducts, bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues, treatment and surgery for joint disorders, freeing of muscle attachments).

Limited dental care given for Accidental Injury to Sound Natural Teeth within 12 months following the accident; in no event will the Plan pay for the repair or replacement of dentures, crowns or other dental devices.

Benefits are also available for Hospital or other Facility charges for dental-related services that require a Hospital inpatient or outpatient admission due to an underlying medical condition.

**(8)** **Durable Medical Equipment/Braces/Prosthetics/Devices.** Services or supplies related to duplicate medical equipment, braces, Prosthetics or other devices or the replacement of Durable Medical Equipment, braces, Prosthetics or other devices (unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional) due to misuse, loss, theft or destruction, or natural disaster, unless approved in advance by the Claims Administrator. The purchase of Durable Medical Equipment that can be rented unless the length of time that the equipment will be needed makes the purchase less costly than the rental. The purchase or replacement of any Biomechanical Prosthetic Device. Specialized equipment when standard equipment is adequate for the patient's condition. Services or supplies related to durable equipment, braces, Orthotics, or splints that are primarily for athletic use. Charges for routine maintenance or delivery.

The Claims Administrator will determine Covered Services and Supplies for Durable Medical Equipment, Prosthetics, and Orthotics.

**(9)** **Educational/Cognitive/Therapy for Developmental/Birth Defects.** Services and supplies covered under a municipality's early intervention program mandated by law or that any school system is required to provide under any law; this applies even if the Covered Person, parent or guardian does not seek provision of such services or supplies through an early intervention program (EIP) or through a school system. Exception: The Plan will consider benefits for Covered Services and Supplies which exceed the recommendations of or which are not available through the EIP or a school system.

**(10)** **Evacuation/Repatriation Charges**. Expenses related to transporting a Covered Person or, in the case of a deceased Covered Person, the remains of a Covered Person, from a foreign country to the United States.

**(11)** **Excess Charges.** The difference between the Allowed Charge and the Provider's actual charge.

**(12)** **Exercise Programs.** Exercise programs for treatment of any condition, except for physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

**(13)** **Expenses not considered "medical care" as defined under Section 213(d) of the Internal Revenue Code.** Any expense that is not considered "medical care" as defined under Section 213(d) of the Internal Revenue Code ("Code"). As defined in Section 213(d) of the Code, the term "medical care" means, among other things, amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of the body.

The term "medical care" under Section 213(d) of the Code does not include, among other things, cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. For this purpose, the term "cosmetic surgery" means any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. Transgender healthcare and gender identity services covered under the Plan as described in Transgender Healthcare and Gender Identity Services section will be considered "medical care."

**(14)** **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/ Investigational or not Medically Necessary, unless as required by federal law.

Exception: Coverage will be provided for off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.

**(15)** **Eye Care.** Radial keratotomy or other eye surgery to correct refractive disorders.

Exceptions: Eye care for aphakic patients and soft lenses or sclera shells intended for use as corneal bandages; eye care as covered under the well child section of this Plan; and periodic routine eye examinations and tests, including refractions, as shown in the Schedules of Benefits.

**(16)** **Foot Care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease). Orthopedic shoes, non-prescriptive inserts or other supportive foot devices.

**(17)** **Foreign Travel.** Care, treatment or supplies out of the USA, if travel is for the sole purpose of obtaining medical services. Exception: Services preauthorized under the Medical Necessity and Preauthorization section of this Plan.

**(18)** **Government Coverage.** Coverage will not be provided for any service or care for which benefits are payable under Medicare or any other federal, state, or local government program, except when required by state or federal law. When you are eligible for Medicare, the Plan will reduce its benefits by the amount Medicare would have paid for the services, regardless of whether or not you are actually enrolled in Medicare. However, this Medicare reduction will not apply to you if one of the following applies:

**(a)** **Eligibility for Medicare by Reason of Age.** You are eligible for benefits under Medicare by reason of your age, and the Participant is in "current employment status" (working actively and not retired) with the Employer.

**(b)** **Eligibility for Medicare by Reason of Disability Other than End-Stage Renal Disease.** You are eligible for benefits under Medicare by reason of disability (other than end-stage renal disease), and the Participant is in "current employment status" (working actively and not retired) with the Employer.

**(c)** **Eligibility for Medicare By Reason of End-Stage Renal Disease.** You are eligible for benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. The Plan will not reduce the Plan's benefits, and the Plan will provide benefits before Medicare pays, during the waiting period. The Plan will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before the Plan provides benefits.

The government exclusion does not apply to Medicaid or where otherwise prohibited by law.

**(19)** **Government Facilities/Institutions.** Services or supplies received in an institution owned or operated by federal, state or local governments. However, benefits will be available for covered expenses for the following exceptions:

**(a)** Veterans Hospital for services and supplies that are unrelated to conditions resulting from military service in the USA armed forces.

**(b)** State or local government-owned acute care Hospital or Skilled Nursing Facility that customarily bills for its services.

**(c)** State or local government-owned mental health facility.

**(d)** Government-owned facility that otherwise meets Plan limitations for coverage as an outpatient alcohol or Substance Use Disorder Facility.

**(e)** USA military acute care Hospital or Skilled Nursing Facility for treatment of retired or inactive military personnel or their dependents or for the dependents of active military personnel.

**(f)** Any government facility, if the patient with a sudden and serious Illness or Injury is treated immediately at a government facility, because of its closeness, and the confinement is only as long as the emergency care is necessary or it is impossible to transfer the patient to another facility.

**(20)** **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a physician, except for wigs for hair loss experienced by patients with cancer, burns or systemic disease.

**(21)** **Hearing.** Services or supplies related to hearing aids, tinnitus masking devices (or similar devices) and examinations to determine the need for adjustments or repair of them.

**Exceptions:** Services covered under the well child section of this Plan; periodic routine hearing exams as shown in the Schedules of Benefits, and hearing aids up to the limit shown in the Schedule of Benefits will be covered. FDA approved cochlear implants will be covered as well as batteries and repairs to the implants that would be the result of normal wear and tear (unless covered by warranty) under the Plan's Prosthetic benefit.

**(22)** **Hospital/Facility Employees.** Professional services billed by a physician or nurse who is an employee of a Hospital, or Skilled Nursing Facility, or any Facility where care is received and paid by the Hospital or Facility for the service. Exception: Hospitalists and Physician Extenders who have contracts for payment with the Claims Administrator.

**(23)** **Illegal Acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of participation in felony, as determined by the laws of the state in which the felony occurred. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

**(24)** **Illegal Care.** Services or supplies considered illegal according to the laws of the state of jurisdiction or according to federal law. Benefits will not be provided if these excluded services are obtained outside the USA even if these services are legal in the foreign country.

**(25)** **Implants.** Claims for implants billed by a Facility may be denied unless they are submitted with the Facility invoice.

**(26)** **Infertility.** Care, supplies, services and treatment for any of the following reproductive services: egg preservation services, in-vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cloning, sperm banking and donor fees associated with artificial insemination or other procedures.

**(27)** **Military Service.** Services or supplies for which benefits are, or can be, provided due to related Illness or Injury arising from the past or present military service in the armed forces of any government or international authority.

**(28)** **Missed Appointments/Forms/No Care Given.** Medical summaries, invoice preparation, completion of claim forms, or fees for missed appointments, charges for standby services. Services or supplies not actually received by the patient or incurred by someone other than the patient unless specifically included in this Plan such as coverage limits for organ donors.

**(29)** **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

**(30)** **Non-Emergency Medical Condition Hospital Admissions.** Care and treatment billed by a Hospital for diagnostic studies. Care and treatment billed by a Hospital for non-Emergency Medical Condition admissions on a Friday or a Saturday; this does not apply if surgery is performed within 24 hours of admission.

**(31)** **Non-traditional medical services, treatments and supplies** (e.g., alternative medicine) which are not specified as covered under this Plan.

**(32)** **No Obligation to Pay.** Charges incurred for which the Plan has no legal obligation to pay.

**(33)** **No Physician Recommendation.** Care, treatment, services or supplies not recommended and approved by a Provider; or treatment, services or supplies when the Covered Person is not under the regular care of a physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

**(34)** **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Exceptions: (a) Nutritional counseling or therapy and (b) surgical and non-surgical charges for Morbid Obesity which meet the Claims Administrator's medical policy criteria are

covered.

**(35)** **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. Payment will not be made even if you or your Qualifying Dependents do not claim the entitled benefits, such as Workers' Compensation.

**(36)** **Over-the-Counter.** Over-the-counter drugs and supplies are not covered, unless otherwise required by law.

**(37)** **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, support (non-surgical) stockings, non-Prescription Drugs and medicines, first aid supplies and non-Hospital adjustable beds, as well as telephone, radio, television, or barber services charged by any facility or other Provider.

**(38)** **Plan Design Excludes.** Charges excluded by the Plan design as specified in this document.

**(39)** **Prohibited Referral.** Any pharmacy services, clinical laboratory, radiation therapy, x-ray or imaging services which were provided pursuant to a referral prohibited by the New York State Public Health Law or similar laws in other states, if service is rendered out of New York.

**(40)** **Routine Care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Appendices - Schedule of Benefits.

Physical exams and/or diagnostic testing and immunizations related to premarital, occupational, school, camp, sports, or citizenship/immigration medical screening, whether or not mandated under any law, regulation, or policy.

**(41)** **Services Before or After Coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

**(42)** **Surgical Sterilization Reversal.** Care and treatment for the reversal of surgical sterilizations.

**(43)** **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a physician, except for ambulance charges as defined as a covered service or transportation services specifically listed in this Plan.

**(44)** **War.** Any loss that is due to a declared or undeclared act of war.

# PRESCRIPTION DRUG BENEFITS

### Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Please refer to https://hr.syr.edu/benefits/health-benefits/prescription-drug-coverage for prescription drug information.

### Copayments/Coinsurance

The Copayment or Coinsurance amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the Schedule of Benefits. This amount is not reimbursable as a Covered Service and Supply under the medical portion of the Plan.

The Plan will follow the provision of the federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan.

Any one participating retail pharmacy prescription or mail order prescription is limited to a 90-day supply as indicated by the prescribing Provider.

If a drug is purchased from a non-participating pharmacy or a participating pharmacy when the Covered Person's ID card is not used, then you can submit a reimbursement form to the prescription drug claims administrator. Please refer to Syracuse University's Office of Human Resources website to obtain this form: https://hr.syr.edu/benefits/health-benefits/prescription-drug-coverage.

### Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for extended periods of time). Certain drugs and medications are not available for home delivery.

### Special Requirements

The prescription drug program may contain requirements for pre-authorizations, quantity limits, specialty pharmacy services and utilization management programs such as step therapy. Please contact the prescription drug claims administrator for further details.

### Mandatory Generic Drug Substitution Program

To encourage the use of generics, if a generic equivalent is available and you choose to have the brand name drug, or your doctor prescribes the script "Dispense As Written" (DAW), you will be required to pay the difference between the actual cost of the brand name drug and the amount the plan would have paid for the generic equivalent.

A generic drug is chemically equivalent to the original brand name drug. The only difference is that the brand name manufacturer's patent has expired, allowing other manufacturers to sell the drug. As a result, the generic manufacturer does not incur research costs and can charge significantly less for the drug.

### Covered Prescription Drugs

A complete list of covered drugs is available by contacting the prescription drug claims administrator. Information on how to contact the administrator can be found on Syracuse University's Office of Human Resources website: https://hr.syr.edu/benefits/health-benefits/prescription-drug-coverage.

Certain preventive medications are required to be covered under the federal Patient Protection and Affordable Care Act. Please contact Member Services for details on current requirements which do not require Cost-Sharing. Please note that a prescription must be obtained from the Provider and supplied to the pharmacist to have the claim processed through the claims system. Age and other criteria apply for certain drugs. In most circumstances, the plan will offer coverage for preventive generic drugs only; if a generic version is not available or would not be medically appropriate for the patient as determined by the attending physician, the brand name drug will be available at no cost share, subject to reasonable medical management.

Effective for tests obtained on or after January 15, 2022 during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), the Plan will provide coverage, without Cost-Sharing, prior approval or any other medical management requirements, for COVID-19 at home over-

the-counter (OTC) tests administered and read at home that are authorized, approved or cleared by the Federal Drug Administration regardless of whether or not a Provider administered, ordered or prescribed such test. The most common tests are brands BinaxNOW™, CLINITEST®, Flowflex™, i-Health®, InteliSwab™, On/Go™ QuickVue® and COVID-19 at-home test kits (Roche). For purposes of this section, the "emergency period" ended on May 11, 2023.

COVID-19 OTC tests are limited to eight (8) tests per Covered Person, per 30-day period. COVID-19 OTC tests obtained from participating and non-participating pharmacies, retail stores or online retailers are combined for purposes of the limitation described above. If there are multiple COVID-19 OTC tests in one package, each test in the package will count towards the limit. For example, if you purchase two (2) kits, each containing four (4) tests, the limit would be two (2) kits (total of eight (8) tests) per Covered Person per 30-day period. This limit does not apply to COVID-19 OTC tests that are ordered or prescribed by a Provider. COVID-19 OTC tests that are ordered or prescribed by a Provider are Covered Services under the Comprehensive Medical Benefits section of this booklet and not this Prescription Drug Benefits section.

There are three (3) ways in which you may obtain COVID-19 OTC tests:

**(1)** **Pay Out-of-Pocket and Submit to the Plan for reimbursement.** If you purchased and paid out-of-pocket for COVID-19 OTC tests from a participating or non-participating pharmacy, retail store or online retailer, you will need to submit to the Plan for reimbursement, on a form prescribed by Optum Rx. You may file your claim for reimbursement online or by printing a copy and mailing in a paper reimbursement form. For instructions on how to submit your claim online or for a copy of a paper claim form and instructions on where to mail your claim, you may visit optumrx.com/testinfo or call the customer service number on your ID card. Please refer to the **Prescription Drug Claims Procedures and Appeals** section of this booklet for the applicable claim and appeal filing timelines. You will be reimbursed for the cost of each eligible test up to a maximum reimbursement of $12 per test. If you purchased the COVID-19 OTC test on or after January 15, 2022, but prior to February 1, 2022, this $12 per test maximum reimbursement limit does not apply.

**(2)** **Visit a Preferred Network Pharmacy.** As of February 1, 2022, the Plan has a direct payment provider network available. If you visit the pharmacy counter at Kinney Drugs, Rite Aid (including Bartell Drugs), Sam's Club, Walgreens or Walmart and show your ID card, you will receive COVID-19 OTC tests without any additional out-of-pocket costs to you. For additional information, you may also visit optumrx.com/testinfo.

**(3)** **Order Online through the Optum Store.** As of February 1, 2022, the Plan has a direct-to-consumer shipping program available. You may go to the optumrx.com website and log in. If you do not have an account, you may register for one. You may also call the customer service number on your ID card or, for additional information, visit optumrx.com/testinfo.

Effective as of May 12, 2023, the Plan does not provide coverage for COVID-19 OTC tests.

**Limits to This Benefit**

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge.

The Out-of-Pocket Limit for Prescription Drugs is $2,000 per Covered Person with a maximum of $4,000 per family in a Calendar Year. This Out-of-Pocket Limit is separate from the Out-of-Pocket Limit applied to medical benefits described in this booklet.

The covered drug charge for any one prescription will be limited to:

**(1)** Refills only up to the number of times specified by a physician.

**(2)** Refills (of non-controlled medications) up to one year from the date of order by a physician.

**(3)** Quantity limits that could apply to controlled substances based on state regulations.

In addition to the above, Prescription Drugs to treat Infertility are limited to $20,000 per Lifetime and are not considered an Essential Health Benefit.

**Expenses Not Covered Under the Prescription Drug Benefit**

This benefit will not cover a charge for any of the following:

**(1)** **Administration.** Any charge for the administration of a covered Prescription Drug.

**(2)** **Allergy Sera.**

**(3)** **Bulk Chemicals.**

**(4)** **Dietary/Vitamin Supplements.** A charge for dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription, prescription vitamins, and vitamin supplements as required under the Patient Protection and Affordable Care Act.

**(5)** **Blood** or blood plasma products except those covered as specialty medications.

**(6)** **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

**(7)** **Devices.** Except where specifically covered by the Plan, devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, prescribed and non-prescribed outpatient supplies, or any similar device.

**(8)** **Drugs Used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes, such as Retin A, or medications for hair growth or removal. Drugs covered under the Plan as described in Transgender Healthcare and Gender Identity Services section will not be considered drugs used for cosmetic purposes.

**(9)** **Electrolyte Replacement Products.**

**(10)** **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

**(11)** **FDA.** Any drug not approved by the Food and Drug Administration.

**(12)** **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance. Note, certain growth hormones are covered if approved by the Claims Administrator via a prior authorization.

**(13)** **Homeopathic Treatments.**

**(14)** **Immunization.** Immunization agents, vaccines, or biologicals except those covered as specialty medications. Note, certain immunizations are covered under the pharmacy benefit. Please contact the Claims Administrator for more information on specific coverage.

**(15)** **Inpatient Medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

**(16)** **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".

**(17)** **Medical Exclusions.** A charge excluded under Medical Plan Exclusions.

**(18)** **No Charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

**(19)** **No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to drugs or medications as required under the Patient Protection and Affordable Care Act.

**(20)** **Non-legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

**(21)** **Nutritional supplements** and combination nutritional products.

**(22) Ostomy supplies.**

**(23) Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the physician.

# CLAIM PROVISIONS

## HOW TO SUBMIT A CLAIM

**Benefits under this Plan shall be paid only if the Claims Administrator decides in its discretion that a Covered Person is entitled to them.**

In-Network Provider benefits are always paid directly to the In-Network Provider. Benefits for Hospitals or other Facilities that are Out-of-Network Providers are generally paid directly to the Hospital or Facility if charges have not been paid by you. All other Allowed Charges are generally paid directly to you.

The Plan prohibits assignment of benefits. All rights to benefits under the Plan are personal to you. Your rights and benefits under the Plan cannot be assigned, sold, or transferred to a third party, including your health care Provider. This includes your right to payment or reimbursement for benefits under the Plan and your right to file a lawsuit to recover benefits due to you under the Plan. Any purported assignment of rights or benefits is void and will not be recognized by the Plan. The Claims Administrator may issue payments directly to your Providers for covered services you receive (whether or not pursuant to an authorization). The Claims Administrator's payment to your Provider, however, does not create an assignment of benefits and it will not constitute a waiver of the application of this anti-assignment provision. The prohibition of assignments does not take away your ability to designate an authorized representative to file claims for benefits or to file appeals as part of the Plan's internal claims and appeals process described below.

When the claim is processed, Excellus will send you an Explanation of Benefits (EOB) statement attached to your benefit payment (if applicable). This information should be carefully reviewed to make sure the charges were submitted to Excellus correctly and that the claim was processed accurately.

Please note that you will not receive an EOB statement in the mail if you are only responsible for the Coinsurance, Copayment or Deductible under the Plan. All EOB documents and health statements are accessible online to view and print at the Excellus website at: www.excellusbcbs.com. You will need to register on this site to view your EOB statements. If you have not yet registered, select "Sign-Up" on the home page and follow the instructions to create an account (be sure to have your Excellus member identification card available).

When a Covered Person has a claim to submit for payment that person must:

**(1)** Obtain a claim form from Syracuse University's Office of Human Resources by calling 315.443.4042, or emailing hrservice@syr.edu. A claim form is also found on the following website: hr.syr.edu/forms.

**(2)** Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

**(3)** Attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Member ID number
- Name of patient
- Name, address, telephone number of the Provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges
-

**(4)** Send the above to the Claims Administrator at this address:

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

**Prescription Drug Claims**

Obtain a reimbursement form found on Syracuse University's Office of Human Resources website: hr.syr.edu/benefits/health-benefits/prescription-drug-coverage and mail to the address as indicated on the form.

**WHEN CLAIMS SHOULD BE FILED**

Claims should be filed with the Claims Administrator within 12 months of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred.

Claims filed later than that date may be declined or reduced unless this Plan is the secondary payer and the claim which was timely filed with another entity or insurer is submitted within 120 days from the date of Final Benefits Determination.

## CLAIMS PROCEDURE AND APPEALS - MEDICAL

**CLAIMS PROCEDURES AND APPEALS**

The following is a description of how the Plan processes claims for benefits. A "claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. A Claim does not include a request for a determination of an individual's eligibility to participate in the Plan. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination." When a Claim relates to Out-of-Network Provider services described in the section of the booklet titled "**SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS**" and under the requirements of the No Surprises Act you are not responsible for any additional payment to the Out-of-Network Provider other than the Cost-Sharing amount determined in accordance with that section of the booklet, a denial of payment to the Out-of-Network Provider by the Plan, or a dispute as to the amount of payment to the Out-of-Network Provider by the Plan is not considered an Adverse Benefit Determination and is not subject to the claims and appeals process described in this section. Such a dispute will be resolved between the Plan and the Out-of-Network Provider in accordance with the requirements of the No Surprises Act. Payments for services rendered by an Out-of-Network Provider (other than those that are subject to the surprise bill rules described in the "SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS" section of this booklet) may be made payable to the Employee. Payments for services rendered by an Out-of-Network Provider that are subject to the surprise bill rules described in the "SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS" section of this booklet) will be made directly to the Out-of-Network Provider.

The Claims Administrator may request medical records to evaluate any Claim for Plan coverage.

You have the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Step Two Appeal process, as described below, the Plan's decision is known as a "Final Adverse Benefit Determination."

Should you receive notice of a denial at the end of the Step One or Step Two Appeal process, or if the Plan does not follow the Appeal procedures properly, you then have the right to request an independent external Appeal. Please note that you may also choose to apply for an external Appeal if (a) you and the Plan agree in writing to waive any internal Appeal, or (b) your Claim is urgent and the timeframe for completing an expedited internal Appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function. The external Appeal procedures are only available if your Appeal:

(1) involves medical judgment, including a determination of Medical Necessity, medical appropriateness, health care setting, level of care, or effectiveness of a Covered Service;

(2) is for a rescission of coverage;

(3) involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections of the No Surprises Act (see the section of the booklet titled **SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS** for information about how the Plan complies with those requirements); or

(4) involves whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction and Equity Act (MHPAEA) and its implementing regulations.

The external Appeal procedures are described below under **External Appeals**.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

If you believe that your Claim was improperly denied, you may file a lawsuit after at least the Step One Appeal process is completed. If a lawsuit is brought, it must be filed within three (3) years after the date you received the service for which you want the Plan to pay.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal procedures or the external Appeal process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. The Plan Administrator has delegated authority and responsibility for deciding initial Claims and Step One and Step Two internal Appeals to Excellus Health Plan, Inc. for medical Claims, and to Optum Rx for prescription drug Claims. References to the “Claims Administrator” in these procedures means Excellus Health Plan, Inc. for medical Claims and Optum Rx for prescription drug Claims. Step Three (voluntary) internal Appeals are decided by the Administrative Benefits Committee of Syracuse University, which is the Plan Administrator. If you have any questions regarding these procedures, please contact the Plan Administrator or the Claims Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Claims Administrator (or Plan Administrator, in the case of Step Three Appeals) must decide whether to approve or deny the Claim. The Claims Administrator’s or Plan Administrator's notification to you of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Claims Administrator or Plan Administrator, you may be notified that the period for providing the notification will need to be extended.

If the period is extended because the Claims Administrator or Plan Administrator needs more information from you, you must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Claims Administrator or Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, you have the right to file an Appeal. The Claims Administrator or Plan Administrator must make a decision regarding the Appeal and, if the Appeal is denied, provide notice to you within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures.

Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

**Urgent Care Claim**

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize your life or health; or your ability to regain maximum function; or in the opinion of the attending or consulting physician, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A physician with knowledge of your medical condition may determine if a Claim is one involving Urgent Care. If there is no such physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

| | |
|---|---|
| Excellus will notify you of the initial benefit determination | 72 hours after receipt of the Claim |
| If Excellus receives insufficient information on the Claim, or if you or your physician fail to follow the Plan's procedure for filing a Claim, the following will occur: | |
| Excellus will notify you of the above, orally or in writing | 24 hours after receipt of the Claim |
| You must respond to Excellus, orally or in writing | 48 hours after receipt of the request for additional information |
| Excellus will provide you with the benefit determination, orally or in writing | 48 hours after receipt of your response |
| If you request a Step One Appeal or Step Two Appeal, Excellus will notify you of the benefit determination | 72 hours after receipt of your Appeal |

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, you may submit a request for an expedited Appeal orally or in writing. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and you by telephone, facsimile, or other similarly expeditious method. Alternatively, you may request an expedited review under the external Appeal process, if the Claim (i) is eligible for external Appeal (as described in EXTERNAL APPEALS below) and (ii) the timeframe for completing an expedited internal Appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function.

**Concurrent Care Claims**

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs you that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify you sufficiently in advance of the effective date of the reduction or elimination of treatment to allow you to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to a Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

| | |
|---|---|
| If you are receiving an ongoing course of treatment, Excellus will notify you if either of the following occurs: | |
| Reduction or termination before the end of treatment | Prior advance notification will be provided prior to the expiration of the previously approved course of treatment to allow you sufficient time to file an Appeal |
| Approval of an extension of a previously approved course of Urgent Care treatment | 24 hours after receipt of Claim, provided the Claim is made to the Plan at least 24 hours prior to the expiration of the preapproved period of time or number of treatments |
| Excellus will notify you of rescission of coverage | 30 days |
| | |
| Excellus will notify you of determination if you Appeal an Urgent Care Claim | 72 hours after receipt of the Claim |
| | |
| Excellus will notify you of the Adverse Benefit Determination if you request a Step One Appeal or a Step Two Appeal of a Pre-Service Claim (defined below) | 15 days after receipt of Appeal |
| | |
| Excellus will notify you of the Adverse Benefit Determination if you request a Step One Appeal or a Step Two Appeal of a Rescission of coverage | 30 days after receipt of Appeal |

**Pre-Service Claim**
A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-authorization. Please see the **Medical Necessity and Preauthorization** section of this booklet for further information about what benefits require preauthorization.

In the case of a Pre-Service Claim, the following timetable applies:

| | |
|---|---|
| Excellus will notify you of a benefit determination | 15 days after receipt of Claim |
| | |
| If Excellus requires an extension of time to consider your Claim due to matters beyond the control of the Plan | 15 days after receipt of the Claim |
| | |
| If Excellus receives insufficient information on the Claim | |
| | |
| Excellus will notify you | 15 days after receipt of the Claim |

| | |
|---|---|
| You must respond to Excellus | 45 days after receipt of request for additional information |
| | |
| Excellus will notify you, orally or in writing, of failure to follow the Plan's procedures for filing a Claim | 5 days after receipt of the Claim |
| | |
| Excellus will notify you of an Adverse Benefit Determination if you request a Step One Appeal or Step Two Appeal | 15 days after receipt of Appeal |

**Post-Service Claim**

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre- Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services that you have already received.

In the case of a Post-Service Claim, the following timetable applies:

| | |
|---|---|
| Excellus will notify you of an Adverse Benefit Determination | 30 days after receipt of Claim |
| | |
| If Excellus requires an extension of time to consider your Claim due to matters beyond the control of the Plan | 30 days after receipt of the Claim |
| | |
| If Excellus requires an extension of time to consider your Claim due to insufficient information | 30 days after receipt of the Claim |
| | |
| You must respond to Excellus regarding a notice of insufficient information | 45 days after receipt of the request for additional information |
| | |
| Excellus will notify you of an Adverse Benefit Determination if you request a Step One Appeal or Step Two Appeal | 30 days after receipt of Appeal |

**Notice to Claimant of Adverse Benefit Determinations**

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three (3) days of the oral notification, the Claims Administrator or Plan Administrator shall provide written or electronic notification of any Adverse Benefit Determination or Final Adverse Determination. The notice will state, in a manner calculated to be understood by you:

**(1)** The date of service, the health care provider, and the Claim amount, if applicable.

**(2)** A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

**(3)** The specific reason or reasons for the Adverse Benefit Determination.

**(4)** Reference to the specific Plan provisions on which the determination was based and the Plan's standard, if any, that was used in denying the Claim.

**(5)** A description of any additional material or information necessary for you to perfect the Claim and an explanation

of why such material or information is necessary.

**(6)** A description of the Plan's internal Appeals and external Appeal procedures, including information about how to initiate an Appeal, and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following the Step One or Step Two Appeal process.

**(7)** Following a denial on Appeal, a statement regarding the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal Claims and Appeals and external Appeal processes.

**(8)** Following a denial on Appeal, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

**(9)** You will also automatically be provided, free of charge, any new or additional rationale or evidence considered, relied upon, or generated by the Plan, or at the direction of the Plan, in connection with the Claim with sufficient notice, assuming the Plan has received the information in a timely manner, so that you have a reasonable opportunity to respond.

**(10)** If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to you upon request.

**(11)** If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances will be provided upon request.

In addition, the notice will include any other content required under the Patient Protection and Affordable Care Act of 2010 and its implementing regulations ("PPACA").

**INTERNAL APPEALS**

Internal Appeals shall be administered in accordance with PPACA and its regulations, as amended.

After you receive notice of an Adverse Benefit Determination, you, or an authorized representative acting on behalf of you, may submit a request for a review of the Adverse Benefit Determination. The Plan provides for three (3) levels of Appeal (Step One, Step Two and Step Three). In general, should you wish to Appeal an Adverse Benefit Determination, you must first commence a Step One Appeal. If the Step One Appeal is denied, you may: (a) commence a Step Two Appeal; (b) pursue an external Appeal if your Claim is eligible for external Appeal (as described in **EXTERNAL APPEALS** below); or (c) pursue a civil action under Section 502 of ERISA.

If you receive a denial pursuant to both the Step One and Step Two Appeals process, and you desire to further pursue your Claim, you have a right to either (a) participate in a voluntary third Appeal that is conducted by the University's Administrative Benefits Committee (the Step Three Appeal), or (b) pursue a civil action under Section 502 of ERISA. You may also have a right to an external Appeal of a denial of coverage if your Claim is eligible for external Appeal (as described in **EXTERNAL APPEALS** below).

Expedited External Appeal. As an exception to the general rules described above, if (i) your Claim is eligible for external appeal (as described in **EXTERNAL APPEALS** below), and (ii) your Claim is urgent and the timeframe for completing an expedited internal Appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function, you may file for an expedited external Appeal following an Adverse Benefit Determination at any level of review (i.e., following the initial Adverse Benefit Determination or following the Step One, Step Two or Step Three Appeal).

Details regarding the Plan's Appeal process are described more fully below.

Step One Appeal

When you receive an Adverse Benefit Determination, you or an authorized representative acting on your behalf have **180 days** following receipt of the notification in which to Appeal the decision under a Step One Appeal.

You may also file for an expedited external Appeal of your Claim if the Claim (i) is eligible for external Appeal (as described in **EXTERNAL APPEALS** below), and (ii) the timeframe for completing an expedited internal Appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function. You may (but are not required to) file a Step One Appeal and pursue an expedited external Appeal of your Claim simultaneously. For further details regarding expedited external Appeal, please see the external Appeal process described below.

Under the Step One Appeal process, you may submit written comments, documents, records, and other information relating to the Claim. You will be provided, free of charge and upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The Plan will initiate its review of an Adverse Benefit Determination once the Appeal is filed in accordance with plan procedures, regardless of whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

**(1)** was relied upon in making the benefit determination;

**(2)** was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

**(3)** demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

**(4)** constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by you relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by someone who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Plan or Claims Administrator shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

Step One Appeals can be mailed to:

Excellus Health Plan, Inc.
Attn: Advocacy Department
P.O. Box 4717
Syracuse, NY 13221
Telephone No.: 800.493.0318 (TTY: 800.662.1220)
Fax.: 315.671.6656
Email: cc.special.direct@excellus.com

Step Two Appeal

If the adverse determination is maintained after the Step One Appeal, you are allowed a second Appeal to the Claims Administrator within **90 days** of receiving the denial notice of the first Appeal, in accordance with the procedure described above. You may also file for an external Appeal of your Claim if it is eligible for external Appeal (as described in **EXTERNAL APPEALS** below).

You may file for an expedited external Appeal of your Claim if (i) it is eligible for external Appeal (as described in **EXTERNAL APPEALS** below) and (ii) the timeframe for completing an expedited internal Appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function. You may also pursue a civil action under Section 502 of ERISA. You may (but are not required to) file a Step Two Appeal and pursue an expedited external Appeal of your Claim simultaneously. For further details regarding external Appeals and expedited external Appeals, please see the **EXTERNAL APPEALS** section below described below.

The Claims Administrator will notify you of its decision by mail, unless the Claim is an Urgent Care Claim, in which case the Claims Administrator's notification will be done by telephone, facsimile, or other similar expeditious method.

If the adverse determination of a Claim for benefits is maintained after the Step Two Appeal process, you may (a) request a Step Three Appeal, (b) request an external Appeal of your Claim if your Claim is eligible for external appeal (as described in **EXTERNAL APPEALS** below), or (c) pursue a civil action under Section 502 of ERISA.

Step Two Appeals can be mailed to:

Excellus Health Plan, Inc.
Attn: Advocacy Department
P.O. Box 4717
Syracuse, NY 13221
Telephone No.: 800.493.0318 (TTY: 800.662.1220)
Fax: 315.671.6656
Email: cc.special.direct@excellus.com

Step Three Appeal (Voluntary)

A Step Three Appeal is completely voluntary by you. Your Step Three Appeal will be subject to review by the Administrative Benefits Committee ("Committee"). This Appeal must be submitted within **90 days** from the date you received the Step Two Appeal denial from the Claims Administrator.

If the adverse determination of a Claim for benefits is maintained after the Step Three Appeal process, you may pursue civil action under Section 502(a) of ERISA or you may request an external Appeal of your Claim if your Claim is eligible for external Appeal (as described in **EXTERNAL APPEALS** below).

For assistance on how to file a Step Three Appeal, contact Syracuse University's Office of Human Resources by calling 315.443.4042.

Mail the Step Three Appeal to:

Administrative Benefits Committee
c/o Excellus Health Plan, Inc.
Attn: Advocacy Department
P.O. Box 4717
Syracuse, NY 13221
Telephone No.: 800.493.0318 (TTY: 800.662.1220)
Fax: 315.671.6656
Email: cc.special.direct@excellus.com

**Please be sure to mark "confidential" on the envelope.**

The Committee will notify you of its decision by mail.

If you initiate a Step Three Appeal, the following rules shall apply:

**(1)** the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the voluntary Step Three Appeal is pending;

**(2)** you may elect to submit a benefit dispute to the Committee pursuant to the voluntary Step Three Appeal only after completing the Step One and Step Two Appeal process;

**(3)** you shall be provided, upon request, sufficient information relating to the voluntary Step Three Appeal to enable you to make an informed judgment about whether to submit a benefit dispute to the Administrative Benefits Committee under the Step Three Appeal process, including a statement that your decision as to whether or not to submit a benefit dispute to the Administrative Benefits Committee under the Step Three Appeal process will have no effect on your rights to any other benefits under the Plan and information about the applicable rules, your right to representation, the process for selecting any decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process.

The Plan waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to the Committee pursuant to the Step Three Appeal process.

**EXTERNAL APPEALS**

**(1) Your Right to an External Appeal**

This provision shall be in accordance with PPACA and its implementing regulations, as amended. Under certain circumstances, you have a right to an external Appeal of a denial of coverage. Specifically, you or your representative have a right to an external Appeal to an Independent Review Organization ("IRO") if the Adverse Benefit Determination is based on a determination:

(a) that involves medical judgment, including, but not limited to, a determination of Medical Necessity, medical appropriateness, health care setting, level of care, or effectiveness of a Covered Service, or a determination that the service is an Experimental or Investigational treatment, including clinical trials and treatments for rare diseases;
(b) that is a rescission of coverage;
(c) involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections of the No Surprises Act (see the section of the booklet titled **SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS** for information about how the Plan complies with those requirements); or
(d) involves whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction and Equity Act (MHPAEA) and its implementing regulations.

**(2) Your Right to Appeal a Determination that a Service is not Medically Necessary**

If the Plan has denied coverage on the basis that the service does not meet the Plan's Medically Necessary requirements, you may Appeal to an IRO if you satisfy the following criteria:

**(a)** The service, procedure, or treatment must otherwise be a Covered Service and Supply under the Plan; and one of the following has occurred:

- You received an Adverse Benefit Determination after a Step One or Step Two Appeal under the Plan's internal Appeal process, or
- You and the Plan have agreed in writing to waive any internal Appeal, or
- You are applying for an expedited external Appeal at the same time as you apply for an expedited internal Appeal, or

- The Plan fails to adhere to Claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

**(3) Your Right to Appeal a Determination that a Service is Experimental or Investigational**

If the Plan has denied coverage on the basis that the service is an Experimental or Investigational treatment, you must satisfy the following criteria:

**(a)** The service must otherwise be a Covered Service and Supply under the Plan; and one of the following has occurred:

- You received an Adverse Benefit Determination after a Step One or Step Two Appeal under the Plan's internal Appeal process, or
- You and the Plan agreed in writing to waive any internal Appeal, or
- You are applying for an expedited external Appeal at the same time as you apply for an expedited internal Appeal, or
- The Plan fails to adhere to Claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

**(4) The External Appeal Process**

If, through the Plan's internal Appeal process, you have received an Adverse Benefit Determination on your Step One or Step Two Appeal, upholding a denial of coverage that involves any of the four (4) reasons identified in (1) above entitled **"Your Rights to an External Appeal"**, you have four (4) months from receipt of such notice to file a written request for an external Appeal. If you and the Plan have agreed in writing to waive any internal Appeal, you have four (4) months from receipt of such waiver to file a written request for an external Appeal. If the Plan fails to adhere to Claim processing requirements, you have four (4) months from such failure to file a written request for an external Appeal. The Plan will provide an external Appeal application with the Adverse Benefit Determination issued through the Plan's Step One or Step Two Appeal process or its written waiver of an internal Appeal.

You must then submit the completed application to the Claims Administrator at the address indicated on the application. If you satisfy the criteria for an external Appeal, the Claims Administrator will forward the request to an IRO.

Within five (5) days following the date of receipt of the external Appeal request, a preliminary review will be completed to determine whether:

**(a)** You were covered under the Plan at the time the Claim was incurred.

**(b)** The denial was based on your ineligibility under the Plan.

**(c)** You completed at least a Step One Appeal under the Plan's internal Claim process, if required.

**(d)** You have provided all necessary information and forms required to process the external Appeal.

Within one (1) business day after completion of the preliminary review, you will be notified in writing if your Appeal is not eligible for external Appeal. If your request is complete, but not eligible for external Appeal, the notification will include the reasons for ineligibility. If your request is not complete, the notification will describe the information or materials needed to complete the Appeal. You will have the remainder of the four (4) month filing period, or 48 hours, whichever is greater, to fix any issues with your Appeal.

If your Claim is eligible for external Appeal, it will be submitted to an IRO. The decision of the IRO will be provided to you in a written notice within 45 days. If the IRO reverses the Plan's determination, the Plan will immediately provide coverage or payment for the Claim.

**Expedited External Appeal**

You have the right to an expedited external Appeal in the following situations:

**(a)** Following an Adverse Benefit Determination involving a medical condition for which the timeframe for completion of an expedited internal Appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you filed a request for an expedited external Appeal.

**(b)** Following a Final Adverse Benefit Determination, if the timeframe for completion of a standard external Appeal of your Claim would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but you have not been discharged from the facility.

Immediately upon the receipt of the request for expedited external Appeal a determination will be made regarding whether the request satisfies the criteria for an expedited external Appeal described above and you will be provided notice regarding the IRO's determination.

If the Claim is eligible for expedited external Appeal, the Plan will provide all necessary documents and information considered in making the Adverse Benefit Determination or Final Adverse Benefit Determination to the IRO. The IRO will provide a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the expedited external Appeal request. If the notice is not in writing, the IRO will provide written confirmation of the decision within 48 hours after providing the initial notice.

External Appeals are final and binding. This means that following the IRO's decision, you are not permitted to pursue any other applicable internal Appeal option that would otherwise have been available. The IRO's decision is binding on both you and the Plan, except to the extent other remedies are available under State or Federal law. The IRO's decision is admissible in any court proceeding.

The Plan will not charge you a fee for an external Appeal.

**(5) Your Responsibilities**

**It is your RESPONSIBILITY to initiate the external Appeal process.** You may initiate the external Appeal process by filing a completed application with the Claims Administrator. You may appoint a representative to assist you with your external Appeal request; however, the Claims Administrator may contact you and request that you confirm in writing that you have appointed such representative.

**Covered Services/Exclusions**

In general, the Plan does not cover a service that is not Medically Necessary or considered Experimental or Investigational. However, the Plan shall cover a service that is not Medically Necessary or is considered an Experimental or Investigational treatment if it is approved by an IRO in accordance with the External Appeal Procedures Section of this booklet. If the IRO approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of Experimental and/or Investigational drugs or devices, the costs of non- health care services, the costs of managing research, or costs which would not be covered under the Plan for non-Experimental or non-Investigational treatments provided in such clinical trial.

**Construction Clause**

Notwithstanding any provision in this "CLAIMS PROCEDURE AND APPEALS - MEDICAL" section ("Claims Section") to the contrary, the parties intend that this Claims Section (1) will comply with the benefit Claims procedure

requirements for non-grandfathered plans under the Patient Protection and Affordable Care Act of 2010 and its implementing regulations ("PPACA"), (2) shall be interpreted and applied to the full extent possible in a manner that is consistent with that intention, and (3) shall incorporate by reference any other requirements that might be necessary from time to time to help ensure full compliance with PPACA's benefit Claims procedure requirements (if there is any inconsistency between such incorporated requirement and any provisions of this Claims Section, the terms of the incorporated requirement shall control).

**PRESCRIPTION DRUG CLAIMS PROCEDURES AND APPEALS**

Step One Appeal

If you are not satisfied with the decision regarding your benefit coverage or you receive an Adverse Benefit Determination following a request for coverage of a prescription drug Claim (including a Claim considered and "deemed" denied because missing information was not timely submitted), you have the right to Appeal the Adverse Benefit Determination in writing within 180 days of receipt of notice of the initial coverage decision to the prescription drug claims administrator. An Appeal may be initiated by you or your authorized representative (such as your physician). To initiate an Appeal for coverage, provide in writing:

**(1)** Your name
**(2)** Member ID
**(3)** Phone number
**(4)** The prescription drug for which benefit coverage has been denied
**(5)** Any additional information that may be relevant to yourAppeal

A decision regarding your Appeal will be sent to you within 15 days of receipt of your written request for pre- service Claims or 30 days of receipt of your written request for post-service Claims. If your Appeal is denied, the denial notice will include information to identify the Claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external Appeal processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the Claims and Appeals processes and any additional information needed to perfect your Claim. You have the right to a full and fair impartial review of your Claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your Appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available. If you do not speak English well and require assistance in your native language to understand the letter or your Claims and Appeals rights, please call the prescription drug Claims administrator.

Step One Appeals may be mailed to:

Optum Rx Prior Authorization Department
PO Box 5252
Lisle, IL 60532-5252
Telephone No.: 866.854.2945 (TTY: 711)
Fax: 866.511.2202

Step Two Appeal

If you are not satisfied with the coverage decision made on your Appeal, you may request in writing to the prescription drug claims administrator, within 90 days of the receipt of notice of the decision, a second level Appeal, or pursue an external Appeal as described below, if your Claim is eligible for external Appeal (as described below). You may file for an expedited external Appeal of your Claim if (i) it is eligible for external Appeal (as described below) and (ii) the timeframe for completing an expedited internal Appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function. A second level Appeal may be initiated by you or your authorized representative (such as your physician).

To initiate a second level Appeal, provide in writing:

**(1)** Your name
**(2)** Member ID
**(3)** Phone number
**(4)** The prescription drug for which benefit coverage has beendenied

**(5)** Any additional information that may be relevant to your Appeal

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service Claims or 30 days of receipt of your written request for post-service Claims. If the Appeal is denied, the denial notice will include information to identify the Claim involved, the specific reasons for the decision, new or additional evidence, if any, considered by the plan in relation to your Appeal, the plan provisions on which the decision is based, a description of applicable external Appeal processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the Claims and Appeals processes. You have the right to a full and fair impartial review of your Claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level Appeal, and present evidence and testimony as part of your Appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available. If you do not speak English well and require assistance in your native language to understand the letter or your Claims and Appeals rights, please call the prescription drug claims administrator. If new information is received and considered or relied upon in the review of your second level Appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this Appeal.

If your Step One or Step Two Appeal is denied and you are not satisfied with the decision of the prescription drug claims administrator, or your initial benefit denial notice or any Appeal denial notice does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you have the right to bring a civil action under ERISA section 502(a).

In addition, as noted above, if your Claim is eligible for external Appeal (as described below) and your Step One or Step Two Appeal is denied and you are not satisfied with the decision on Appeal or your initial benefit denial notice or any Appeal denial notice does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you have the right to an independent review by an independent external review organization. Details about the process to Appeal your Claim and initiate an external Appeal will be described in any notice of an Adverse Benefit Determination and are also described below. The right to an independent external Appeal is only available for certain Claims (as described below)

Step Two Appeals may be mailed to:

Optum Rx Prior Authorization Department
PO Box 5252
Lisle, IL 60532-5252
Tel: 1.866.854.2945 (TTY: 711)
Fax: 1.866.511.2202

Step Three Appeal (Voluntary)

A Step Three Appeal is completely voluntary. Your Step Three Appeal will be subject to review by the Administrative Benefits Committee ("Committee"). This Appeal must be submitted within **90 days** from the date that you received the Step Two Appeal denial from the prescription drug claims administrator. After the Step Two Appeal process, you can then decide to follow the Step Three Appeal process, follow the external Appeal process or file a Step Three Appeal as well as an external Appeal.

For assistance on how to file a Step Three Appeal, contact the Office of Human Resources by calling 315.443.4042.

Mail the Step Three Appeal to:

Administrative Benefits Committee
c/o Office of Human Resources, Syracuse University Skytop
Office Building, Skytop Road
Syracuse, NY 13244
hrservice@syr.edu

**Please be sure to mark "confidential" on the envelope.**

The Committee will notify you of its decision by mail.

If you initiate the Step Three Appeal, the following rules shall apply:

**(1)** the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the voluntary Step Three Appeal is pending;

**(2)** you may elect to submit a benefit dispute to the Committee pursuant to the voluntary Step Three Appeal only after completing the Step One and Step Two Appeal process;

**(3)** you shall be provided, upon request, sufficient information relating to the voluntary Step Three Appeal to enable you to make an informed judgment about whether to submit a benefit dispute to the Administrative Benefits Committee under the Step Three Appeal process, including a statement that your decision as to whether or not to submit a benefit dispute to the Administrative Benefits Committee under the Step Three Appeal process will have no effect on your rights to any other benefits under the Plan and information about the applicable rules, your right to representation, the process for selecting any decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process.

The Plan waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to the Committee pursuant to the Step Three Appeal process.

**Urgent Appeal (Expedited Review)**

You have the right to request an urgent Appeal of an Adverse Benefit Determination (including a Claim considered denied because missing information was not timely submitted) if your situation is urgent. An urgent situation is one where in the opinion of your attending Provider, the application of the time periods for making non-Urgent Care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your Claim. To initiate an urgent Claim or Appeal request, you or your physician (or other authorized representative) must contact the prescription drug claims administrator. Claims and Appeals submitted by mail will not be considered for urgent processing unless and until you call or fax and request that your Claim or Appeal be considered for urgent processing.

In the case of an urgent Appeal (for coverage involving Urgent Care), you will be notified of the benefit determination within 72 hours of receipt of the Claim. If the Appeal is denied, the denial notice will include information to identify the Claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your Appeal, the plan provisions on which the decision is based, a description of applicable external Appeal processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the Claims and Appeals processes. You have the right to a full and fair impartial review of your Claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your Appeal, and present evidence and testimony as part of your Appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available. If you do not speak English well and require assistance in your native language to understand the letter or your Claims and Appeals rights, please contact the prescription drug claims administrator. If new information is received and considered or relied upon in the review of your Appeal, such information will be provided to you together with an opportunity to respond prior to issuance of any final adverse determination. The decision made on your urgent Appeal is final and binding. In the Urgent Care situation, there is only one level of Appeal prior to an external Appeal.

If your Appeal is denied and you are not satisfied with the decision of the Appeal (i.e., your “Final Adverse Benefit Determination”) or any Appeal denial notice (i.e., “Adverse Benefit Determination notice” or “Final Adverse Benefit Determination”) does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), you have the right to bring a civil action under ERISA section 502(a).

In addition, if your Claim is eligible for external Appeal (as described below), if your Appeal is denied and you are not satisfied with the decision or your initial benefit denial notice or any Appeal denial notice does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), you have the right to an independent review by an independent external review organization.

In addition, in urgent situations where the appropriate timeframe for making a non-Urgent Care determination would seriously jeopardize your life or health or your ability to regain maximum function, you also have the right to immediately request an urgent (expedited) external Appeal, rather than waiting until the internal Appeal process, described above, has been exhausted, provided you file your request for an internal Appeal of the Adverse Benefit Determination at the same time you request the independent external Appeal. If you are not satisfied or you do not agree with the determination of the independent external review organization, you have the right to bring a civil action under ERISA section 502(a).

Details about the process to Appeal your Claim and initiate an external Appeal will be described in any notice of an Adverse Benefit Determination and are also described below. The right to an independent external Appeal is only available for Claims that involve:

(a) medical judgment, including, but not limited to, a determination of Medical Necessity, medical appropriateness, health care setting, level of care, or effectiveness of a Covered Service, or a determination that the service is an Experimental or Investigational treatment, including clinical trials and treatments for rare diseases (Claims based purely on the terms of the plan--e.g., plan only covers a quantity of 30 tablets with no exceptions--generally would not qualify as a medical judgment Claim);
(b) a rescission of coverage;
(c) consideration of whether the Plan is complying with the surprise billing and cost-sharing protections of the No Surprises Act (see the section of the booklet titled **SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS** for information about how the Plan complies with those requirements); or
(d) whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction and Equity Act (MHPAEA) and its implementing regulations.

**External Appeal Procedures**

The right to an independent external Appeal is only available for the type of Claims described above. You can request an external Appeal by an Independent Review Organization (IRO) as an additional level of Appeal prior to, or instead of, filing a civil action with respect to your Claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external Appeal, you must complete at least the Step One Appeal process described above, unless your Claim and Appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit Claims and Appeals, or your Appeal is urgent. In the case of an urgent Appeal, you can submit your Appeal in accordance with the above process and also request an external Appeal at the same time, or alternatively you can submit an urgent external Appeal after you have completed the Step One Appeal process.

To file for an external Appeal, your external Appeal request must be received within four months of the date of the Adverse Benefit Determination *or Final Adverse Benefit Determination.* Please note, if the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day. Your request should be mailed or faxed to the prescription drug claims administrator.

**Non-Urgent External Appeal**

Once you have submitted your external Appeal request, your Claim will be reviewed within five business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and you will be notified within one business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your Appeal information will be compiled and sent to the IRO within five business days. The IRO will notify you in writing that it has received the request for an external Appeal and if the IRO has determined that your Claim involves medical judgment or rescission, the letter will describe your right to submit additional information within ten business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the prescription drug claims administrator for reconsideration. The IRO will review your Claim within 45 calendar days and send you, the Plan and the prescription drug claims administrator written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a). If the IRO has determined that your Claim is not eligible for external Appeal (as described above), the IRO will notify you in writing that your Claim is ineligible for a full external Appeal and you have the right to bring civil action under ERISA section 502(a).

**Urgent External Appeal**

Once you have submitted your urgent external Appeal request, your Claim will immediately be reviewed to determine if you are eligible for an urgent external Appeal. An urgent situation is one where in the opinion of your attending Provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your Claim.

If you are eligible for urgent processing, your Claim will immediately be reviewed to determine if your request is eligible to be forwarded to an IRO, and you will be notified of the decision. If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your Appeal information will be compiled and sent to the IRO. The IRO will review your Claim within 72 hours and send you, the plan and the prescription drug claims administrator written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

# TEMPORARY TOLLING OF CERTAIN TIMEFRAMES

The Plan will disregard days occurring during the "Outbreak Period" (as defined below), for purposes of determining the date by which an individual (e.g., a Participant, claimant, Qualifying Dependent, Qualified Beneficiary) has to:

**(1)** request mid-year enrollment in medical coverage due to a HIPAA special enrollment event where the special enrollment period otherwise would include any day of the Outbreak Period;
**(2)** elect to initially enroll in COBRA continuation coverage if the 60-day initial election period otherwise would include any day of the Outbreak Period;
**(3)** make an initial or any subsequent COBRA premium payment if the time period (or the grace period) for making the COBRA premium payment otherwise would include any day of the Outbreak Period;
**(4)** provide a required notice to the Plan of a COBRA qualifying event, if the time period for providing the notice otherwise would include any day of the Outbreak Period;
**(5)** file an initial claim for benefits under the Plan if the timely filing period otherwise would include any day of the Outbreak Period;
**(6)** file an internal (i.e. Step One, Step Two or Step Three Appeal) or external appeal in response to an adverse benefit determination if the time period for filing an internal or external appeal otherwise would include any day of the Outbreak Period; or
**(7)** perfect a request for external appeal in response to a notice that the request is not complete if the time period for perfecting the request otherwise would include any day of the Outbreak Period.

In all cases where a time period referred to in (1)-(7) above began before March 1, 2020, in determining the extended time period based on the above rule, any period of time prior to March 1, 2020 will be subtracted from the time period that would apply without the extension to determine the remaining time frame in which a covered person has to act after the end of the Outbreak Period. For example, for a special enrollment request that is subject to a 30-day special enrollment period, if the special enrollment period started on February 15, 2020, (i) the period from February 15 through February 29 will count as the first 14 days of the 30-day period (leaving 16 days in the special enrollment period), (ii) the entire Outbreak Period (in this example, March 1, 2020 through February 28, 2021) will be disregarded and (iii) the special enrollment period will end 16 days after the end of the Outbreak Period, on March 16, 2021.

Coverage with respect to (2), (3) and (4) above, may be retroactive to the date of the qualifying event; provided the Covered Person makes any required premium payments prior to the end of the extended time period provided for above.

For purposes of this section, the "Outbreak Period" is the period beginning on the later of (1) March 1, 2020 or (2) the "Applicable Event Date" (as defined below) and ending on the earlier of (A) one year from the Applicable Event Date or (B) 60 days after May 11, 2023. In no case will the Outbreak Period for any event last longer than one year or begin before March 1, 2020 or after the date described in (B) above.

For purposes of this section, the "Applicable Event Date" is determined under the following chart, based on which event (from events (1) through (7) above) has occurred:

| Event | Event Type | Applicable Event Date |
|---|---|---|
| (1) | Special enrollment event | First day of special enrollment period |
| (2) | Initial COBRA election | First day of 60-day COBRA election period |
| (3) | Initial COBRA payment<br>Monthly COBRA payment | First day of 45-day initial payment period<br>First day of 30-day payment grace period |
| (4) | COBRA qualifying event notice | First day of 60-day period for providing notice |
| (5) | Initial claim | Date of claim |
| (6) | Internal or external appeal | Date of receipt of claim denial |
| (7) | Perfection of external appeal | Date of receipt of notice of need for information |

# COORDINATION OF BENEFITS

**Coordination of the Benefit Plans.** Coordination of benefits sets out rules for the order of payment of Covered Services and Supplies when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's spouse/Domestic Partner is covered by this Plan and by another plan, or the couple's covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received. **This section does not apply to the prescription drug benefits provided under the Plan**.

**A Covered Person is required to give this Plan information regarding enrollment in other coverage, including Medicare.**

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will in general pay the balance due up to 100% of the total Allowed Charges. When the Plan is secondary, the Plan pays the difference between the Allowed Charge and the primary payer's payment up to the lesser of the balance of the bill or the Plan's normal benefit. Exception: See also Medicare Integration described below.

For a charge or fee to be allowable, at least part of it must be covered under this Plan.

**Benefit plan.** This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

**(1)** Group or group-type plans, including franchise or blanket benefit plans.

**(2)** Blue Cross and Blue Shield group plans.

**(3)** Group practice and other group prepayment plans.

**(4)** Federal government plans or programs. This includes, but is not limited to Medicare and Tricare.

**(5)** Other plans or programs required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

**(6)** No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network Provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network Provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network Provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

For Medicare integration, see section below.

**Automobile Limitations.** When medical payments are available under vehicle insurance, the Plan shall pay excess benefits and reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

**Benefit Plan Payment Order.** When two or more plans provide benefits for the same allowable charge, benefit payment will be as follows:

**(1)** Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

**(2)** Plans with a coordination provision will pay their benefits up to the Allowable Charge:

**(a)** The benefits of the plan which covers the person directly (that is, as an employee, member or

subscriber) are determined before those of the plan which covers the person as a dependent.

**(b)** The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

**(c)** The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

**(d)** When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

- **(i)** The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- **(ii)** If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

**(e)** When a child's parents are divorced or legally separated, these rules will apply:

- **(i)** This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
- **(ii)** This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.
- **(iii)** This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, if the plan has actual knowledge of such decree, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.
- **(iv)** If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

**(f)** For parents who were never married to each other, the rules apply as set out above in **(d)** above as long as paternity has been established.

**(g)** If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowed Charges when paying secondary.

**(3)** Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD

coordination period). Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

**(4)** If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

**(5)** The Plan will pay primary to Tricare or a state child health plan to the extent required by federal law.

**Claims Determination Period.** Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

**Right to Receive or Release Necessary Information.** To make this provision work, this Plan may give to or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. **A Covered Person is required to give this Plan the information it asks for about other plans and their payment of allowable charges.**

**Facility of Payment.** This Plan may repay other plans for benefits paid that the Claims Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

**Right of Recovery.** This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

**Exception to Medicaid.** In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

# MEDICARE INTEGRATION WHEN MEDICARE IS PRIMARY

If a Covered Person is eligible for Medicare they must enroll in both Medicare Parts A and B as soon as such eligibility begins. However, if this Plan is obligated by law to pay its benefits before Medicare, this requirement will not apply. Please refer to the "Government Coverage" exclusion under the **Plan Exclusions** section of this booklet.

**A Covered Person is required to give this Plan information regarding eligibility for an enrollment in Medicare.**

If a Covered Person fails to enroll in Medicare Parts A and B when they are required to do so under the terms of this Plan, then Plan benefits will be reduced following the Medicare Payment Integration rules listed below. The amount of the benefit reduction will be based on the Allowed Charges and the Claims Administrator's reasonable estimate of the amount of Medicare benefits that would have been paid for a properly enrolled Medicare beneficiary.

If Medicare is the primary payer for you or your Qualifying Dependent(s), then the benefits of the Plan will be integrated with Medicare coverage as follows:

**(1) Medicare Payment Integration**.

(a) If the claim is covered by the Plan and also covered by Medicare, the Plan will apply the Medicare allowed amount to the eligible benefits covered under the Plan, subtract the Covered Person's Cost-Sharing responsibility under the Plan, then subtract the amount that Medicare has paid on the claim before making the Plan payment for such claim. If the Medicare paid/payable amount covers 100% of the claim, then no payment under the Plan will be made.

- Medicare allowed amount
- Less Covered Person's Cost-Sharing responsibility under the Plan
- Less Medicare benefit payment
- Equals the Plan payment of the claim

**Example:**
***Note: This example assumes that both the Medicare Part B Deductible and Plan Deductible have been satisfied.***
Medicare allowed amount is $200
Covered Person's Cost-Sharing is $50 Copayment
Medicare benefit payment is $120
Plan payment is $30

If Medicare does not pay 100% of the claim and the claim payment calculated above is less than zero, the Plan payment will be zero for such claim and, any excess amount will be used to reduce the Cost-Sharing responsibility of the Covered Person under the Plan.

(b) If the claim is covered by the Plan, but not covered by Medicare or in instances in which there is no Medicare rate, the Plan will apply its normal reimbursement formula (in accordance with the Allowed Charge definition in the Defined Terms section of this booklet) to the total eligible charges of a claim and then will subtract any Cost-Sharing for the same claim before making the Plan payment for such claim. The Plan's payment of a claim is determined as follows:

- Allowed Charge
- Less Covered Person's Cost-Sharing responsibility under the Plan
- Equals the Plan payment of the claim

**Example:**
***Note: This example assumes that both the Medicare Part B Deductible and Plan Deductible have been satisfied.***
Allowed Charge is $75
Covered Person's Cost-Sharing is $50 Copayment
Plan payment is $25

(c) For a Covered Person who retired prior to 2006 and has not reached age 70, as defined in the Syracuse University Retiree Medical Benefits Plan, the Plan shall pay the difference between the total eligible charges of a Medicare-eligible claim under the Plan and the Medicare reimbursement amount for the same claim, or the amount the Plan would have paid for such claim in the absence of Medicare, if less.

**(2) Medicare Part C (Medicare Advantage).** This integration will not apply when Medicare and a Medicare-sponsored Advantage Plans deny coverage due to its enrolled beneficiary's failure to abide by the HMO or Participating Provider Program requirements. This Plan will not cover the expenses for those services or supplies and Plan benefits will not be paid.

# THIRD PARTY RECOVERY PROVISION

## RIGHT OF SUBROGATION AND REIMBURSEMENT

**When this Provision Applies.** The Covered Person may incur medical or covered dental charges due to Injuries or Illness caused by the act or omission of a Third Party, or for which a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or an insurer, for payment of the medical or dental charges.

The Plan Administrator may, in its sole discretion, deny such charges or authorize conditional interim benefit payments for medical or covered dental expenses that would otherwise be covered by the Plan. However, any such payments are subject to the Plan's Subrogation and Reimbursement rights. By accepting benefits under this Plan such medical or covered dental expenses, a Covered Person automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer, including but not limited to the Covered Person's insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer. In addition, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

**(1)** automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

**(2)** cannot assign any rights against any Third Party or insurer without express written consent of the Plan; and

**(3)** must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

**Amount Subject to Subrogation or Refund.** The Covered Person agrees to recognize the Plan's right to Subrogation and Reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Illness, including a priority over any claim for non-medical or dental charges, attorneys' fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Reimbursement rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its legal costs and attorneys' fees if the Plan needs to file suit in order to recover payment for medical or dental expenses from the Covered Person. Also, the Plan's Subrogation and Reimbursement rights will not be limited by equitable defenses, and the Plan's right to Subrogation and Reimbursement still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole. Specifically, the Plan's rights will not be limited by the "Common Fund Doctrine," "Attorney's Fund Doctrine," "Make Whole Doctrine," "Collateral Source Doctrine," or other similar doctrine.

When a right of Recovery exists, the Covered Person will notify the Plan, in writing, of any potential legal claim(s) the Covered Person may have against any third party for acts that caused expenses to be paid or become payable by the Plan. The Covered Person must provide this notice within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition. The Covered Person will execute and deliver all required instruments and papers as well as do whatever else is needed to secure the Plan's right of Subrogation and Reimbursement as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate or obtain Reimbursement. If the Covered Person receives payment as part of a settlement or judgment from any third party as a result of the act or omission of a Third Party, and the Plan alleges some or all of those funds are due and owed to it, the Covered Person agrees to hold

those settlement funds in trust, either in a separate bank account in the Covered Person's name or in the Covered Person's attorney's trust account as an equitable lien. The Covered Person agrees to serve as a trustee over those funds to the extent of the amount the Plan has paid.

**Conditions Precedent to Coverage.** The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's Reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its Reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Illness caused by a responsible Third Party until after the Covered Person or his or her authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar Reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

**Defined Terms.**

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person or his/her designee by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Illness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Reimbursement" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Illness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

**Recovery from Another Plan Under Which the Covered Person is Covered.** This right of Reimbursement also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan, workers' compensation coverage or any liability plan.

**Rights of Plan Administrator.** The Plan Administrator has a right to deny or make conditional payments, and to request reports on and approve of all settlements.

# CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Covered Persons covered under the Syracuse University Medical Benefits Plan and the Syracuse University Retiree Medical Benefits Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Covered Persons, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is the Administrative Benefits Committee of Syracuse University. The contact information for the Plan Administrator is:

Syracuse University
621 Skytop Road, Suite 1001
Syracuse, New York 13244
Fax: 315.443.1063
Email: **hrservice@syr.edu**

COBRA continuation coverage for the Plan is administered by the COBRA Administrator. For additional information, please contact the COBRA Administrator:

Lifetime Benefit Solutions, Inc.
333 Butternut Drive
Syracuse, NY 13214
Phone No.: 800.493.0318 (TTY: 800.662.1220)
Fax: 315.671.9869

Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Covered Persons who become Qualified Beneficiaries under COBRA.

**What is COBRA Continuation Coverage?** COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “Qualifying Event.” Specific Qualifying Events are listed below. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a “Qualified Beneficiary.” Covered Persons and their eligible family members could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

**Who Can Become a Qualified Beneficiary?** In general, a Qualified Beneficiary can be:

**(1)** Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Participant or a Qualifying Dependent of a covered Participant.

**(2)** Any child who is born to or placed for adoption with a covered Participant during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical child support order. As an exception, an eligible dependent child who is born or placed for adoption with a covered Participant during a period of COBRA continuation coverage immediately becomes a Qualified Beneficiary. The COBRA period for such a child is measured from the same date as for other Qualified Beneficiaries arising from the Qualifying Event, not from the date the child became enrolled in COBRA continuation coverage. The term “placed for adoption” includes an adoption without a preceding placement.

**(3)** A covered Participant who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the US Code with respect to the Employer, as is the Qualifying Dependent of such a covered Participant if, on the day before the bankruptcy Qualifying Event, the Qualifying Dependent was a beneficiary under the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Participant is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a

Qualified Beneficiary, then a Qualifying Dependent of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Note: In addition, although not required by law, the Domestic Partner of a covered Participant (and the eligible dependent child of such an individual) will be treated as a Qualified Beneficiary under the Plan and be entitled to COBRA-like continuation coverage, provided such individual satisfies the requirements for continuation coverage specified by the Office of Human Resources.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Participant during a period of COBRA continuation coverage) will be offered the opportunity to make an independent election to receive COBRA continuation coverage.

**What is a Qualifying Event?** A Qualifying Event is any of the following events where the Covered Person would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

**(1)** The death of a covered Participant.

**(2)** The termination (other than by reason of the Participant's gross misconduct), or reduction of hours, of a covered Participant's employment. Termination of employment or reduction of hours is not a Qualifying Event with respect to coverage under the Syracuse University Retiree Medical Benefits Plan or the Syracuse University Retiree Prescription Drug Plan.

**(3)** The divorce or legal separation of a covered Participant from the Participant's spouse.

**(4)** The dissolution of domestic partnership of a covered Participant and the Participant’s Domestic Partner.

**(5)** A covered Participant's entitlement in any part of the Medicare program.

**(6)** A child’s ceasing to satisfy the Plan's requirements for coverage as a Qualifying Dependent (for example, a child that attains the maximum age to be a Qualifying Dependent under the Plan).

**(7)** A proceeding in bankruptcy under Title 11 of the US Code with respect to an Employer from whose employment a covered Participant retired at any time.

If the Qualifying Event causes the covered Participant, or the Qualifying Dependent of the covered Participant, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Participant, or the Qualifying Dependent of the covered Participant, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA"), as amended, does not constitute a Qualifying Event. A Qualifying Event will occur, however, if a Participant does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Participant and covered Qualifying Dependents will be entitled to COBRA continuation coverage even if they failed to pay the Participant portion of premiums for coverage under the Plan during the FMLA leave.

**Special Note to Syracuse University Employees Losing Medical Plan Coverage by Reason of Retirement**: Upon retirement from employment with the University, you and your Qualifying Dependents will be provided with the option to elect Continuation Coverage. You may also be eligible to enroll in the Syracuse University Retiree Medical Plan. If you elect Continuation Coverage of your active medical benefits upon retirement, you lose your eligibility to enroll in the Retiree Medical Plan. If you enroll in the Retiree Medical Plan, you will not be provided with an opportunity to enroll in Continuation Coverage when your retiree medical benefits terminate, except as identified in **Qualifying Event (7)** listed above. Your Qualified Beneficiaries may have a limited right, at their own expense, to elect

Continuation Coverage if the requirements identified in **Qualifying Events (3), (4), (6), or (7)** above are satisfied. If you have any questions regarding your coverage options at retirement, please contact the Office of Human Resources.

**What Factors should be Considered When Determining to Elect COBRA Continuation Coverage?** You should take into account that a failure to continue your group health coverage will affect your rights under federal law.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's/Domestic Partner's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you will probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

**What is the Procedure for Obtaining COBRA Continuation Coverage?** The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**What is the Election Period and How Long Must it Last?** The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

**Is a Covered Participant or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?** The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

**(1)** the end of employment or reduction of hours of employment,

**(2)** death of the Participant, or

**(3)** commencement of a proceeding in bankruptcy with respect to the Employer.

**For other Qualifying Events (such as divorce, legal separation, dissolution of domestic partnership, a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse/domestic partner or dependent child who loses coverage will not be offered the option to elect COBRA continuation coverage.**

**You must send this notice to the Plan Administrator.**

**NOTICE PROCEDURES**:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Syracuse University
Office of Human Resources
621 Skytop Road, Suite 1001
Syracuse, New York 13244
Fax: 315.443.1063
Email: hrservice@syr.edu

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

**(1)** the **name of the plan or plans** under which you lost or are losing coverage,
**(2)** the **name and address of the Participant** covered under the Plan,
**(3)** the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
**(4)** the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the court-approved legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA **continuation** coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Participants may elect COBRA continuation coverage for their spouses/Domestic Partners, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Qualifying Dependents do not elect COBRA continuation coverage within the 60-day election period described above, the right to elect COBRA continuation coverage will be lost.

**Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?** If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**There May be Other Options Available When You Lose Group Health Coverage.** Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, Medicare, or Children's Health Insurance Program (CHIP) (**healthcare.gov/medicaid-chip/childrens-health-insurance-program**), or other group health plan coverage options (such as coverage under a Spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.HealthCare.gov**.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it may be difficult or impossible to

switch to another coverage plan.

**Additional information about enrolling in Medicare instead of COBRA Continuation Coverage:**
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8 month special enrollment period (visit: **medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods**) to sign up for Medicare Part A or B, beginning on the earlier of:

**(1)** The month after your employment ends; or
**(2)** The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Medicare Part B late enrollment penalty and you may have a gap in coverage if you decide you want Medicare Part B later. As described in the following paragraph, you could also be responsible for significant medical expenses if you don't enroll in Medicare coverage. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan will terminate your COBRA coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA continuation coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. It is important to keep in mind that if your coverage under the Plan is COBRA continuation coverage, the Plan will generally pay as if secondary to Medicare, even if you are not enrolled in Medicare. If you don't enroll in Medicare, you may be responsible for significant medical expenses that are not covered by the Plan (see "Medicare Integration When Medicare is Primary" in this booklet). Visit **medicare.gov/medicare-and-you** for more information.

**Is COBRA Coverage Available if a Qualified Beneficiary Has Other Group Health Plan Coverage or Medicare?**
Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

**When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?** During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

**(1)** The last day of the applicable maximum coverage period.

**(2)** The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

**(3)** The date upon which the Employer ceases to provide any group health Plan (including a successor plan) to any employee.

**(4)** The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation, other than such an exclusion or limitation that does not apply to, the Qualified Beneficiary.

**(5)** The date, after the date of the election that the Qualified Beneficiary becomes entitled to Medicare.

**(6)** In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

**(a)** (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

**(b)** the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the

disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

**What are the Maximum Coverage Periods for COBRA Continuation Coverage?** The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

**(1)** In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

**(2)** In the case of a covered Participant's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Participant ends on the later of:

**(a)** 36 months after the date the covered Participant becomes enrolled in the Medicare program; or

**(b)** 18 months (or 29 months, if there is a disability extension) after the date of the covered Participant's termination of employment or reduction of hours of employment.

**(3)** In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Participant during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

**(4)** In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

**Under What Circumstances can the Maximum Coverage Period be Expanded?** If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.

**How does a Qualified Beneficiary Become Entitled to a Disability Extension?** A disability extension will be granted if an individual (whether or not the covered Participant) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Participant's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Administrator. If, during the period of COBRA continuation coverage, the Social Security Administration determines that the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary or someone on his or her behalf must provide the Plan Administrator with notice of this determination within 30 days after the date of the determination.

**Does the Plan Require Payment for COBRA Continuation Coverage?** For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation

coverage as of the first day of any period for which timely payment is not made.

**Must the Plan Allow Payment for COBRA Continuation Coverage to be Made in Monthly Installments?**
Yes. The Plan is also permitted to allow for payment at other intervals.

**What is Timely Payment for Payment for COBRA Continuation Coverage?** Timely payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Participants or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

**KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**IF YOU HAVE QUESTIONS**
The information above summarizes your rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in the final and proposed regulations published by the U.S. Department of the Treasury. This information is intended to reflect the law and does not grant or take away any rights under the law. Complete information about COBRA and the Plan, including but not limited to, the applicable premium payments and summary plan descriptions, may be obtained by contacting the Syracuse University Office of Human Resources by phone: 315.443.4042, or email: **hrservice@syr.edu**, or the University's designated COBRA Administrator.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **dol.gov/ebsa**. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website. For more information about the Marketplace, visit **HealthCare.gov**.

# MISCELLANEOUS PROVISIONS

## CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, if it is requested, the amount of overpayment will be deducted from future benefits payable.

## MISREPRESENTATION/FRAUD

If it is found that a claim for benefits, or any materials provided for evaluating a claim for benefits under the Plan, contains false information, or that you or your Qualifying Dependents or a Provider conceals, for the purpose of misleading, information concerning any fact material to a claim for benefits thereto, such claim may be denied in total and the Plan Administrator and/or the Claims Administrator may recover any benefits paid to you and/or a Provider. The Plan Administrator may terminate Plan coverage for the submission of a fraudulent claim. In addition, by enrolling a spouse, Domestic Partner or child in coverage, you are representing that the individual satisfies the Plan's eligibility requirements. If you enroll a person who does not satisfy the Plan's eligibility requirements, or if you fail to notify the Syracuse University Office of Human Resources when an enrolled individual ceases to satisfy the eligibility requirements, you will be considered to have made an intentional misrepresentation of material fact or committed fraud, both of which acts are prohibited by the Plan. The ineligible person's coverage may be cancelled as of the date of enrollment or such other date as the Plan Administrator determines to be appropriate. Thirty (30) days of advance notice of rescission will be provided in the case of fraud or intentional material misrepresentation. This paragraph does not affect the right of the Plan Administrator to pursue any criminal or civil remedies that may exist under applicable state or federal law.

## REFUND DUE TO OVERPAYMENT OF BENEFITS

If payment has been made for Covered Services and Supplies under the Plan that are more than the benefits that should have been paid, or for services or supplies that should not have been paid, according to Plan provisions, the Plan Administrator or the Claims Administrator shall have the right to demand a full refund, or may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such Covered Person or other present or future amounts payable to such person, or recover such amounts by any other appropriate method that the Plan Administrator, in its sole discretion, shall decide. By accepting benefits under the Plan each Covered Person authorizes the deduction of such excess payment from such benefits, or other present or future benefit payments.

Payments made in error for services or supplies not covered by this Plan shall not be considered certification of coverage and will not limit the enforcement of any provision of this Plan for any and all claims submitted under the Plan.

## VENUE FOR LEGAL ACTION

If a dispute arises under this Plan, it must be resolved in Federal court or a court located in Onondaga County, New York. You agree not to start a lawsuit against the Plan or the Claims Administrator 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 the Plan or Claims Administrator brings against you.

## CHOICE OF LAW

All disputes relating to this Plan shall be governed by Federal law and, as applicable, the laws of the State of New York.

## AGREEMENTS BETWEEN THE CLAIMS ADMINISTRATOR AND IN-NETWORK PROVIDERS

Any agreement between the Claims Administrator and In-Network Providers may only be terminated by the Claims Administrator or the providers. This Plan and the Claims Administrator do not require any provider to accept a

Covered Person as a patient. Neither the Plan, nor the Employer or the Claims Administrator guarantees a Covered Person's admission to any In-Network Provider or any health benefits program.

**RIGHT TO DEVELOP GUIDELINES AND ADMINISTRATIVE RULES**

The Employer and/or the Claims Administrator may develop or adopt standards that describe in more detail when payment will or will not be made under this Plan. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether emergency care in the outpatient department of a Facility was necessary; or whether certain services are skilled care. Those standards will not be contrary to the descriptions in this booklet. If you have a question about the standards that apply to a particular benefit, you may contact the Claims Administrator at the customer service number located on your ID card and it will explain the standards or send you a copy of the standards. These standards may include medical policy criteria developed by the Claims Administrator. Medical policy criteria are also available at www.excellusbcbs.com/health-wellness/medical-policies. The Employer and/or the Claims Administrator may also develop administrative rules pertaining to enrollment and other administrative matters. The Employer and/or the Claims Administrator shall have all the powers necessary or appropriate to enable them to carry out their duties in connection with the administration of their respective duties under this Plan. These standards, including any medical policy criteria, are updated from time to time without notice and are applied based on your date of service or the date you request prior approval. If you have questions regarding any standard or if you request a copy of any standard, you should be sure to note that your questions or your request is related to the standard that was in place as of your date of service or request for prior approval.

**FURNISHING INFORMATION AND AUDIT**

All persons covered under this Plan will promptly furnish the Employer and/or the Claims Administrator with all information and records that they may require from time to time to perform their obligations under this Plan. You must provide the Plan Administrator and/or the Claims Administrator with information for reasons such as the following: to allow the Employer and/or the Claims Administrator to determine the level of care you need; so that the Employer and/or the Claims Administrator may certify care authorized by your physician; or to make decisions regarding the Medical Necessity of your care.

**ENROLLMENT: ERISA**

The Employer will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages and social security numbers of all group members covered under this Plan, and any other information required to confirm their eligibility for coverage. The Employer will provide the Claims Administrator with the enrollment information including your name, address, age and social security number and advise the Claims Administrator electronically when you are to be added to or subtracted from our list of Covered Persons, on a monthly basis.

**YOUR MEDICAL RECORDS**

In order to provide you with coverage under this Plan, it may be necessary for the Plan Administrator and/or the Claims Administrator to obtain your medical records and information from Facilities, Professional Providers, Providers of Additional Health Services, and pharmacy who provided services to you. Actions to provide that coverage include processing your claims, reviewing Claims and Appeals 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 Plan, the Plan Administrator and/or the Claims Administrator are permitted to obtain and use those records for those purposes.

The Plan Administrator and the Claims Administrator agree to maintain that information in accordance with state and federal confidentiality requirements. However, the Plan Administrator and the Claims Administrator are permitted to share that information with the New York State Department of Health, quality oversight organizations and third parties with which the Plan Administrator and the Claims Administrator contract to assist them in administering this Plan, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

**REPORTS AND RECORDS**

The Plan Administrator and the Claims Administrator are entitled to receive from any provider of services to Covered Persons, information reasonably necessary to administer this Plan subject to all applicable confidentiality requirements. Providers who render services to a Covered Person hereunder are authorized to:

**(1)** Disclose all facts pertaining to the care, treatment and physical condition of the Covered Person to the Plan Administrator and/or the Claims Administrator, or a medical, dental, or mental health professional that the Plan Administrator and/or the Claims Administrator may engage to assist the Plan Administrator and the Claims Administrator in reviewing a treatment or claim, or in connection with a complaint or quality of care review;

**(2)** Render reports pertaining to the care, treatment and physical condition of the Covered Person to the Plan Administrator and/or the Claims Administrator, or a medical, dental, or mental health professional, that the Plan Administrator and/or the Claims Administrator may engage to assist the Plan Administrator and Claims Administrator in reviewing a treatment or claim; and

**(3)** Permit copying of the Covered Person's records by the Plan Administrator and the Claims Administrator as may be necessary for Plan administration purposes.

**SERVICE MARKS**

Excellus Health Plan, Inc. ("Excellus") is an independent corporation organized under the Insurance Law of New York State. Excellus also operates under licenses with the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans, which licenses Excellus to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus does not act as an agent of the Blue Cross and Blue Shield Association. Excellus is solely responsible for its obligations created under the Administrative Services Contract between the Employer and Excellus. The Employer has not entered into the Administrative Services Contract with Excellus based on representations by any person other than Excellus.

**INTER-PLAN ARRANGEMENTS DISCLOSURE - OUT-OF-AREA SERVICES**

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of the Claims Administrator's Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program.

Typically, when accessing care outside the Service Area, you will obtain care from health care providers that have a contractual agreement (i.e., are "In-Network Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Out-of-Network Providers. The Claims Administrator's payment practices in both instances are described below.

**(1)** **BlueCard® Program.** Under the BlueCard® Program, when you access covered health care services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible to Employer for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its In-Network Providers.

Whenever you access covered health care services outside the Claims Administrator's Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

**(a)** The provider's billed covered charges for your Covered Services and Supplies; or
**(b)** The negotiated price that the Host Blue makes available to the Claims Administrator. This negotiated price will be one of the following:

**(i)** Often, a simple discount that reflects an actual price that the Host Blue pays to your provider;
**(ii)** Sometimes, an estimated price that takes into account special arrangements with your provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges; or
**(iii)** Occasionally, an average price based on a discount that result in expected average savings for similar types of providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above.

However, such adjustments will not affect the price the Claims Administrator uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate your liability for any covered health care services according to applicable law.

**(2) Calculation of Member Liability for Services of Out-of-Network Providers outside the Claims Administrator's Service Area.** The Allowed Charge definition in this booklet, as amended from time-to-time, describes how the Claims Administrator's payment (the "Allowed Charge") for covered services of Out-of-Network Providers outside its Service Area is calculated. The Allowed Charge may be based upon the amount provided to the Claims Administrator by the Host Blue or the payment it would make to Out-of-Network Providers inside its Service Area. Regardless of how the Allowed Charge is calculated, you will be liable for the amount, if any, by which the provider's actual charge exceeds the Allowed Charge, which amount is in addition to any other Cost-Sharing (Deductible, Copayment or Coinsurance) required by this Plan.

## FEDERAL LAWS

This Plan shall be governed and construed according to Federal laws such as, but not limited to, the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Public Health Service Act, as applicable, and the Health Insurance Portability and Accountability Act, as amended. Federal laws will affect the provisions of this Plan only when directed at this type of self-funded health Plan for Plan Sponsors regulated by the laws. You may seek assistance or information about your rights under this plan by contacting the closest Employee Benefits Security Administration (EBSA), US Department of Labor shown in your local phone directory or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Ave. N.W., Washington, DC 20210.

# APPENDIX A
# Schedule of Benefits – SUBlue

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service and Supply, please refer to **Covered Services, Plan Exclusions,** and **Defined Terms**. In addition, the Plan's payments for Covered Out-of-Network Benefits described in the booklet section titled "**SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS**" will be determined in accordance with the provisions of that section and may be different than the description in this Schedule.

| Plan Features | SUBlue<br>In-Network Benefits<br><br>(Subject to Allowed Charge) | SUBlue<br>Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Deductible per Calendar Year** | $150 per individual to a maximum of $300 per family | $300 per individual to a maximum of $1,000 per family |
| **Note:* In-network and out-of-network Deductibles aggregate separately. These Deductibles do not apply to Prescription Drug benefits or towards the Prescription Drug Out-of-Pocket Limit. Further Prescription Drug Copayments and/or Coinsurance do not apply to the medical plan's Deductibles or the Out-of-Pocket Limit, as Prescription Drugs have a separate Out-of-Pocket Limit. | | |
| **Common Accident Deductible**<br>Only one (1) Deductible applies when two (2) or more covered family members are injured in the same accident. Only expenses due to that accident and applied against the Plan Deductible count toward this limit. Expenses also count toward the Calendar Year Deductible. | | |
| **Copayments**<br>Only one Copayment is required per Covered Person for all Covered Services and Supplies for each Provider per service date. | See individual Plan features for details. | See individual Plan features for details. |
| **Percentage Coinsurance** | No Coinsurance is required for most Covered Services and Supplies.<br><br>See individual Plan features for details. Exceptions listed in chart below. | The Covered Person pays 30% of the Allowed Charge after any Deductible and/or Copayment for most Covered Services and Supplies. The Plan pays 70% of the Allowed Charge. The Covered Person is also responsible for the difference between the Provider's actual charge and the Allowed Charge. |
| **International Claims**<br>For Covered Persons receiving services in a foreign country, eligible claims will process as an In-Network Benefit, and a Covered Person is only responsible for the in-network Cost-Sharing. For claims incurred outside the Blue Cross Blue Shield Global Core Network, the Allowed Charge is based on the actual charge submitted. | | |
| **Out-of-Pocket Limit per Calendar Year**<br>(Coinsurance, Copayments and/or Deductibles apply to the Out-of-Pocket Limit) | $2,000 per person or<br>$4,000 per family | $6,000 per person or<br>$12,000 per family<br><br>The difference between the Provider's actual charge and the Allowed Charge does not count towards the Out-of-Pocket Limit. |

| Plan Features | SUBlue In-Network Benefits (Subject to Allowed Charge) | SUBlue Out-of-Network Benefits* (Subject to Allowed Charge) |
|---|---|---|
| ***Note:** The in-network and out-of-network Out-of-Pocket Limits are cumulative across both levels. Copayments and/or Coinsurance for Prescription Drugs do not apply to the medical plan's Deductibles or towards the medical plan's Out-of-Pocket Limit. Similarly, medical plan Deductibles, Coinsurance and Copayments do not count towards the Prescription Drug plan's Out-of-Pocket Limit. | | |
| **Maximum Benefit Amounts (Lifetime)** | Unlimited, except for specific services that are not considered Essential Health Benefits. | |
| **Preauthorization** | For preauthorization contact 800.493.0318 (TTY: 800.662.1220). For a full list of services that require a preauthorization, please visit www.excellusbcbs.com. | |

| Preventive Care | SUBlue In-Network Benefits (Subject to Allowed Charge) | SUBlue Out-of-Network Benefits* (Subject to Allowed Charge) |
|---|---|---|
| ***Note:** If an In-Network Provider is not available, with preauthorization, the Plan will cover 100% of the charges of an Out-of-Network Provider and the Deductible will not apply. For preauthorization, please contact 800.493.0318 (TTY: 800.662.1220). | | |
| **Well Child Care and Immunizations from birth to age 19** | The recommendations of the United States Preventive Services Task Force will apply to exams and screenings; the recommendations of the Advisory Committee on Immunization Practices (ACIP) will apply to immunizations. | |
| | The Plan covers 100% of the Allowed Charge. | Deductible, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Newborn Care** | The Plan covers 100% of the Allowed Charge. | Deductible, plus the difference between the actual charge and the Allowed Charge. |
| • Newborn Circumcision | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Adult Care age 19 and older (Limited to one exam per Calendar Year)** | The recommendations of the United States Preventive Services Task Force will apply to exams and screenings; the recommendations of the Advisory Committee on Immunization Practices (ACIP) will apply to immunizations. | |
| • Related tests according to recommended age-appropriate guidelines are covered.<br>• Routine hearing and vision exams are not covered under this section | The Plan covers 100% of the Allowed Charge. | Deductible, plus the difference between the actual charge and the Allowed Charge. |
| • Immunizations according to recommended age-appropriate guidelines are covered. | The Plan covers 100% of the Allowed Charge. | Deductible, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Colorectal Cancer Screening** for persons at (1) increased or high risk for developing colorectal cancer (based on specific personal or family health risk factors); or (2) average risk, beginning at age 45.<br>Benefit applies to all related Facility and Professional Provider charges. | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| Preventive Care | SUBlue In-Network Benefits<br><br>(Subject to Allowed Charge) | SUBlue Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| ***Note:** If an In-Network Provider is not available, with preauthorization, the Plan will cover 100% of the charges of an Out-of-Network Provider and the Deductible will not apply. For preauthorization, please contact 800.493.0318 (TTY: 800.662.1220). | | |
| **Routine Breast Cancer Screenings including Mammography and ultrasounds** (frequency based on age and family history - limited to one (1) screening per Calendar Year for age 35 and older; other screening criteria applies for high risk individuals) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Bone Mineral Density Measurement & Tests** (osteoporosis screening as recommended by a Professional Provider) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Annual Screening - Pelvic Exam, Cervical Cytology/ Pap Smear, and Related Tests for Covered Persons age 18 and older -** limited to (1) one screening per Calendar Year<br><br>**Routine HPV-DNA screening** on recommendation from Professional Provider (FDA guidelines apply) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Women's Preventive Services** include, but are not limited to, coverage for screening, counseling, and contraception management; see the Preventive Care, Well-Woman Preventive Services section for details. | The Plan covers 100% of the Allowed Charge. | Deductible plus the difference between the actual charge and the Allowed Charge. |
| **Routine Annual Prostate Cancer Screening** - limited to one (1) screening per Calendar Year, age 50 and above (other screening criteria applies for high risk individuals) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Vision Exam**<br>(Limited to one (1) exam per 24-consecutive month period) | $35 Copayment, after Deductible for services rendered by a primary care physician or $50 Copayment, after Deductible for services rendered by a specialist. | Deductible, $35 Copayment for services rendered by a Primary Care Physician or $50 Copayment for services rendered by a specialist, and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Hearing Exam** (Limited to one (1) exam per 24-consecutive month period) | $35 Copayment, after Deductible for services rendered by a primary care physician or $50 Copayment, after Deductible for services rendered by a specialist. | Deductible, $35 Copayment for services rendered by a Primary Care Physician or $50 Copayment for services rendered by a specialist, and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| **Preventive Care** | **SUBlue In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| ***Note:** If an In-Network Provider is not available, with preauthorization, the Plan will cover 100% of the charges of an Out-of-Network Provider and the Deductible will not apply. For preauthorization, please contact 800.493.0318 (TTY: 800.662.1220). | | |
| **Nutritional/Dietary Counseling** (for adults with risk factors and both adults and children with obesity) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| | Maximum of 26 visits per Covered Person per Calendar Year. Services must be rendered by a Professional Provider, certified nutritionist or certified or registered dietician. Recommendations of the US Preventive Services Task Force will apply. | |
| **Tobacco Use Cessation Counseling** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| | The recommendations of the US Preventive Services Task Force will apply. Certain tobacco cessation drugs and over-the-counter products are covered under the prescription drug benefit – a prescription is required. | |
| **Genetic Counseling related to BRCA mutations** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| | The recommendations of the US Preventive Services Task Force will apply. | |
| **COVID-19 Vaccine**<br>Effective as of 15 business days after a recommendation is made from the US Prevention Services Task Force or CDC Advisory Committee on Immunization Practices | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| | The recommendations of the US Preventive Services Task Force or CDC Advisory Committee on Immunization Practices (as applicable) will apply. | |

| **Hospital and Other Facilities Expense Benefits** | **SUBlue In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Inpatient Care** (Facility charges)<br><br>Room and board charges limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate, a Medically Necessary private room is covered.<br><br>Maternity care is covered the same as any other Illness. | $350 Copayment, after Deductible. | Deductible, $350 Copayment, and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Nursery Care** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Certified Birthing Center** (Facility charge and admission screening) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Inpatient Mental Health Disorder Care** (Facility charge)<br>• Hospital or psychiatric Facility<br>• Residential care | $350 Copayment, after Deductible. | Deductible, $350 Copayment, and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Inpatient Substance Use Disorder Detoxification and Rehabilitation**<br>• Hospital or Substance Use Disorder Facility<br>• Residential care | $350 Copayment, after Deductible | Deductible, $350 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient Mental Health Disorder Care**<br>• Office visits | $35 Copayment, after Deductible. | Deductible, $35 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • Other outpatient treatment (other than partial hospitalization) | $35 Copayment, after Deductible. | Deductible, $35 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • Partial hospitalization (a separate Copayment applies if there is more than 90 consecutive days between the last service rendered under one treatment plan and the first service rendered under a new subsequent treatment plan) | $200 Copayment, after Deductible. | Deductible, $200 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient Treatment for Substance Use Disorders**<br>• Office visits | $35 Copayment, after Deductible. | Deductible, $35 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • Other outpatient treatment (other than partial hospitalization) | $35 Copayment, after Deductible. | Deductible, $35 Copayment and 30% Coinsurance, plus the difference between |

| **Hospital and Other Facilities Expense Benefits** | **SUBlue In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| | | the actual charge and the Allowed Charge. |
| • Partial hospitalization (a separate Copayment applies if there is more than 90 consecutive days between the last service rendered under one treatment plan and the first service rendered under a new subsequent treatment plan) | $200 Copayment, after Deductible. | Deductible, $200 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Hospital Outpatient Care Services** | **Charges must be billed by the Hospital for its services and supplies. Professional Provider charges are considered separately. Only one Copayment is required per Covered Person for all Covered Services and Supplies for each Provider per service date.** | |
| • **Preadmission Testing** (Facility charge) | The Plan covers 100% of the Allowed Charge. | Deductible, 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Emergency Room** (Facility charge) – Emergency Medical Condition – Copayment is waived if Covered Person is admitted within 24 hours. | $150 Copayment, after Deductible. | $150 Copayment, after in-network Deductible. |
| • **Emergency Room –** (Facility charge) Non-Emergency Medical Condition | $150 Copayment, after Deductible. | $150 Copayment, after in-network Deductible. |
| • **Outpatient Surgery** (Facility charge) | $200 Copayment, after Deductible. | Deductible, $200 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Radiation Therapy** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Chemotherapy** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **IV Therapy** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Dialysis** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Physical Therapy** | $35 Copayment, after Deductible. | Deductible, $35 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Respiratory Therapy** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Speech Therapy** | $35 Copayment, after Deductible. | Deductible, $35 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Cardiac Rehabilitation**<br><br>Limited to a frequency of three (3) times per week and up to a maximum of 18 consecutive weeks for an | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| **Hospital and Other Facilities Expense Benefits** | **SUBlue In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| approved plan of care | | |
| • **Pulmonary Rehabilitation**<br><br>Limited to 36 visits per Covered Person per Lifetime | The Plan covers 100% of the Allowed Charge | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Occupational Therapy** | $35 Copayment, after Deductible. | Deductible, $35 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Diagnostic Breast Cancer Screenings including Mammography and ultrasounds** | The Plan covers 100% of the Allowed Charge | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Diagnostic X-rays and Radiology Services** (see MRI, PET, CT scans below) | $50 Copayment, after Deductible. | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **MRI, PET, CT scans** | $50 Copayment, after Deductible. | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Diagnostic Laboratory Tests** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Diagnostic Machine Tests** | $50 Copayment, after Deductible. | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Hospital Outpatient Clinic Visit** | $50 Copayment, after Deductible. | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Ambulance** | $100 Copayment, after Deductible. | $100 Copayment, after in-network Deductible. |
| **Ambulatory Surgical Center - Freestanding (Facility charge and preadmission testing)** | $150 Copayment, after Deductible. | Deductible, $150 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Inpatient Skilled Nursing Facility (SNF)/Rehabilitation Facility Care –** limited to 180 days per admission (or series of admissions)<br><br>An admission (or series of admissions) that is separated by more than 90 consecutive days is considered to be a separate admission. | $350 Copayment, after Deductible. | Deductible, $350 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| **Hospital and Other Facilities Expense Benefits** | **SUBlue In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Home Health Care**<br><br>Unlimited visits | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Hospice Care**<br><br>Inpatient and outpatient care are unlimited. Bereavement counseling is limited to five (5) visits per family any time prior to or after a person's death, per Calendar Year. | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Urgent Care Facility** | $50 Copayment, after Deductible. | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| **Medical/Surgical Services and Supplies**<br>(Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUBlue In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Surgical Charge Benefits**<br>• **Surgery** (Office and ambulatory surgery) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Assistant Surgeon** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Anesthesia** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Maternity Care**<br>(Physician charges only; Facility charges are covered separately) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Colonoscopy – Therapeutic** (Benefit applies to all related Facility and Professional Provider charges) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **In-Hospital/Facility Physician's Care** (medical, mental health, and substance use disorders) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUBlue In-Network Benefits** (Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **Inpatient Specialist Consultation**<br><br>Limited to one (1) visit per day during a covered admission | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Office/Outpatient Specialist Consultation** (Professional Provider-requested) | $50 Copayment, after Deductible. | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Second Opinion** | The Plan covers 100% of the Allowed Charge. | Deductible plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient Provider Care**<br>Services and supplies must be given and billed by a covered healthcare provider and found Medically Necessary according to Plan provisions in an office, clinic, home or elsewhere. | $35 Copayment, after Deductible if services are rendered by a Primary Care Physician or $50 Copayment, after Deductible if services are rendered by a specialist. | Deductible, $35 Copayment if services are rendered by a Primary Care Physician or $50 Copayment if services are rendered by a specialist, and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Emergency Room Visit**<br>(Professional Provider's charge)<br><br>• Emergency Medical Condition | $50 Copayment, after Deductible. | $50 Copayment, after in-network Deductible. |
| • Non-Emergency Medical Condition | $50 Copayment, after Deductible. | $50 Copayment, after in-network Deductible. |
| **Diagnostic Breast Cancer Screenings including Mammography and ultrasounds** | The Plan covers 100% of the Allowed Charge | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Diagnostic X-ray and Radiology Services** (see MRI, PET, CT scans below)<br><br>• **MRI, PET, CT scans** | $50 Copayment, after Deductible. | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Diagnostic Machine Tests** | $50 Copayment, after Deductible. | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Diagnostic Laboratory and Pathology Tests** (including independent laboratory) | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUBlue In-Network Benefits** (Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19**<br><br>Effective as of 03/13/2020 and during any portion of the emergency period defined in paragraph (1)(B) of the section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)). For purposes of this section the "emergency period" ends on 05/11/2023. | The Plan pays 100% of the Allowed Charge. | The Plan pays 100% of the Allowed Charge. |
| **Genetic Testing** | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Genetic Counseling** | $35 Copayment, after Deductible if services are rendered by a Primary Care Physician or $50 Copayment, after Deductible if services are rendered by a specialist. | Deductible, $35 Copayment if services are rendered by a Primary Care Physician or $50 Copayment if services are rendered by a specialist, and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Allergy Testing and Treatment** (injections and treatment material) | $35 Copayment, after Deductible if services are rendered by a Primary Care Physician or $50 Copayment, after Deductible if services are rendered by a specialist. | Deductible, $35 Copayment if services are rendered by a Primary Care Physician or $50 Copayment if services are rendered by a specialist, and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Allergy Serum** (billed separately from office visit) | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Professional Interpretation Charges** | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Dialysis** | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Clinical Trials** (excludes the actual Clinical Trial) | Covered - see specific expense type.<br><br>Only covers Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. Out-of-network coverage is only available if there is no In-Network Provider available. | Not covered. |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUBlue In-Network Benefits** (Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **Radiation Therapy** | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Chemotherapy** | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **IV Therapy** | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient Treatment for Mental Health Disorders**<br>• Psychological testing is covered | $35 Copayment, after Deductible. | Deductible, $35 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient Treatment for Substance Use Disorders** | $35 Copayment, after Deductible. | Deductible, $35 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Private Duty Nursing – Medically Necessary Inpatient and Outpatient Care** | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Physical Therapy** | $35 Copayment, after Deductible. | Deductible, $35 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Speech Therapy** | $35 Copayment, after Deductible. | Deductible, $35 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Occupational Therapy** | $35 Copayment, after Deductible. | Deductible, $35 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Cardiac Rehabilitation**<br><br>Limited to a frequency of three (3) times per week and up to a maximum of 18 consecutive weeks for an approved plan of care | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Pulmonary Rehabilitation**<br>Limited to 36 visits per Covered Person per Lifetime | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUBlue In-Network Benefits** (Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **Respiratory/Inhalation Therapy** | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Durable Medical Equipment** (other than oxygen and breastfeeding equipment) | 10% Coinsurance, after Deductible. | Deductible and 40% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • Oxygen (to include equipment and supplies) | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • Breastfeeding Equipment Rental or Purchase | The Plan pays 100% of the Allowed Charge. | Deductible and 40% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| | Limited to one (1) rental or purchase per pregnancy. Breast pumps are available out-of-network only if there is no In-Network Provider. The Medical Necessity requirement does not apply in-network or out-of-network. | |
| **Prosthetics** (external) | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Wigs** (for hair loss due to cancer treatment, burns, or systemic disease) | The Plan pays 100% of the Allowed Charge. | The Plan pays 100% of the Allowed Charge. You will be responsible for the difference between the actual charge and the Allowed Charge. |
| **This is not an Essential Health Benefit** | Limited to $500 per Lifetime | |
| **Orthotics** (includes foot orthotics) | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Medical/Surgical Supplies** | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Therapeutic Injections** | $35 Copayment, after Deductible if services are rendered by a Primary Care Physician or $50 Copayment, after Deductible if services are rendered by a specialist. | Deductible, $35 Copayment (if services are rendered by a Primary Care Physician) or $50 Copayment (if services are rendered by a specialist) and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUBlue In-Network Benefits** (Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **Contact Lens/Glasses for Certain Diagnostic Medical Condition** Limited to one (1) pair each 24-consecutive month period | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Nutritional Therapy Other than Diabetes or Mental Health or Substance Use Disorders** - limited to eight (8) visits per Calendar Year with a registered or certified dietician | $50 Copayment, after Deductible. | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Diabetic Supplies** | $30 Copayment, after Deductible. | Deductible, $30 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Diabetic Education** | $35 Copayment, after Deductible if services are rendered by a Primary Care Physician or $50 Copayment, after Deductible if services are rendered by a specialist. | Deductible, $35 Copayment (if services are rendered by a Primary Care Physician) or $50 Copayment (if services are rendered by a specialist) and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Diabetic Equipment** | $30 Copayment, after Deductible. | Deductible, $30 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Chiropractic Care** (including related X-rays) | $50 Copayment, after Deductible. | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Contraceptives administered or supplied in a Professional Provider's office** (prescription implants, injections, and devices only) | The Plan covers 100% of the Allowed Charge. Includes related physician medical care. | Deductible and 50% Coinsurance, plus the difference between the actual charge and the Allowed Charge.<br>Related physician medical care is not included. It is a separate benefit. See the office visit benefit. |
| **Acupuncture** | $50 Copayment, after Deductible. | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **PUVA (Psoralen & Ultraviolet Light Therapy)** | $30 Copayment, after Deductible. | Deductible, $30 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Vision Therapy**<br>Medical Policy guidelines apply. For a copy of the Medical Policy visit www.excellusbcbs.com. | $30 Copayment, after Deductible. | Deductible, $30 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUBlue In-Network Benefits** (Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **Nutritional Supplements for Phenylketonuria and Related Disorders, Enteral Formulas and Modified Food Products** | 10% Coinsurance, after Deductible. | Deductible and 40% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Blood Services** Autologous and **directed** donations are covered. | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| | Covered only when billed by a Facility or certified blood bank. | |
| **Voluntary or Elective Sterilization**<br>• **Males** | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |
| • **Females** | The Plan covers 100% of the Allowed Charge. Includes the Facility and Professional Provider charges. | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |
| **Voluntary or Elective Abortion** | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |
| **Treatment of Morbid Obesity**<br>Medical Policy guidelines apply. For a copy of the Medical Policy visit www.excellusbcbs.com. | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |
| **Dental Care** (due to accidental injury or congenital disease) | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |
| **TMJ**<br>• **Medical related treatment** | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |
| **TMJ**<br>• **Dental related treatment** | Not covered | Not covered |
| **Infertility**<br>**This is not an Essential Health Benefit** | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.) | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.) |
| | Limited to $20,000 per Lifetime | |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUBlue In-Network Benefits** (Subject to Allowed Charge) | **SUBlue Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **Hearing Aids**<br><br>**This is not an Essential Health Benefit** | Deductible, then the Plan pays the lesser of 100% of the Allowed Charge or 50% of the Provider's charge up to a maximum of $750 for single hearing aid and $1,500 for binaural hearing aids. | Deductible, then the Plan pays the lesser of 100% of the Allowed Charge or 50% of the Provider's charge up to a maximum of $750 for single hearing aid and $1,500 for binaural hearing aids. |
| | Limited to once every three (3) Calendar Years | |
| **Biofeedback** | $35 Copayment, after Deductible if services are rendered by a Primary Care Physician or $50 Copayment, after Deductible if services are rendered by a specialist. | Deductible, $35 Copayment (if services are rendered by a Primary Care Physician) or $50 Copayment (if services are rendered by a specialist) and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Radial Keratotomy** | Not covered. | Not covered. |
| **Telehealth**<br>Effective as of 03/16/2020 and through 09/30/2020 | | |
| MDLive providers | The Plan covers 100% of the Allowed Charge. | Not covered. |
| All other Providers | The Plan covers 100% of the Allowed Charge. | The Plan covers 100% of the Allowed Charge. |
| Effective as of 10/01/2020 | | |
| MDLive providers | Normal Plan cost-sharing based on type of service* | Not covered |
| All other Providers | Normal Plan cost-sharing based on type of service*<br><br>* except that for Telehealth related to the furnishing or administration of certain tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, coverage is as described in the section of this booklet titled "In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the Virus that causes COVID-19." | Normal Plan cost-sharing based on type of service*<br><br>* except that for Telehealth related to the furnishing or administration of certain tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, coverage is as described in the section of this booklet titled "In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the Virus that causes COVID-19." |
| **Transgender Services**<br>Medical Policy guidelines apply. For a copy of the Medical Policy visit www.excellusbcbs.com. | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |

| SUBlue - Prescription Drugs | |
|---|---|
| **Annual Deductible** | No Deductible |
| **Out-of-Pocket Maximum** | $2,000 per individual with a maximum of $4,000 for a family |
| | |
| **Retail: Generic** | 20% Coinsurance* |
| **Retail: Brand Formulary** | 25% Coinsurance |
| **Retail: Brand Non-Formulary** | 45% Coinsurance |
| | |
| **Mail Order: Generic** | $20* |
| **Mail Order: Brand Formulary** | $50 |
| **Mail Order: Brand Non-Formulary** | $90 |
| | |
| **Specialty Mail Order (All)** | Same as Mail Order except 30 day supply |
| | |
| **Contraceptives** | Follows above schedule for retail and mail order |
| | |
| **Infertility Prescription Drugs** | Follows above schedule for retail and mail order |
| **This is not an -Essential Health Benefit** | Limited to $20,000 per Lifetime |

*** Generic Prescription Drugs: $0 copay**
**Certain Age and other Restrictions Apply / Prescriptions are Required / Contact Optum Rx at 866.854.2945 (TTY: 711) for further details**

# APPENDIX B
# Schedule of Benefits - SUOrange

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service and Supply. Please refer to **Covered Services, Plan Exclusions,** and **Defined Terms**. In addition, the Plan's payments for Covered Out-of-Network Benefits described in the booklet section titled "**SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS**" will be determined in accordance with the provisions of that section and may be different than the description in this Schedule.

| Plan Features | SUOrange In-Network Benefits (Subject to Allowed Charge) | SUOrange Out-of-Network Benefits* (Subject to Allowed Charge) |
|---|---|---|
| **Deductible per Calendar Year** | $150 per individual to a maximum of $300 per family | Not applicable/No coverage |
| **Common Accident Deductible**<br>Only one (1) Deductible applies when two (2) or more covered family members are injured in the same accident. Only expenses due to that accident and applied against the Plan Deductible count toward this limit. Expenses also count toward the Calendar Year Deductible. | | |
| **Copayments**<br>Only one Copayment is required per Covered Person for all Covered Services and Supplies for each Provider per service date. | See individual Plan features for details. | Not applicable/No coverage |
| **Percentage Coinsurance** | No Coinsurance is required for most Covered Services and Supplies.<br><br>See individual Plan features for details. | Not applicable/No coverage |
| **International Claims**<br>For Covered Persons receiving services in a foreign country, eligible claims will process as an In-Network Benefit, as long as they are provided by an in-network Blue Cross Blue Shield Global Core Network Provider. There is no coverage for services provided by an Out-of-Network Provider, other than for Emergency Services or ambulance services to treat an Emergency Medical Condition. | | |
| **Out-of-Pocket Limit per Calendar Year**<br>(Coinsurance, Copayments and Deductibles apply to the medical plan's Out-of-Pocket Limit. Prescription Drug Copayments and/or Coinsurance do not apply to the medical plan's Deductibles or the Out-of-Pocket Limit, as prescriptions drugs have a separate Out-of-Pocket Limit. Similarly, medical plan Deductibles, Coinsurance and Copayments do not count towards the prescription drug plan's Out-of-Pocket Limit.) | $2,000 per person or<br>$4,000 per family | Not applicable/No coverage |
| **Maximum Benefit Amounts (Lifetime)** | Unlimited, except for specific services that are not considered Essential Health Benefits. | Not applicable/No coverage |
| **Preauthorization** | For preauthorization contact 800.493.0318 (TTY: 800.662.1220). | Not applicable/No coverage |

| **Preventive Care** | **SUOrange In-Network Benefits** (Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| ***Note:** If an In-Network Provider is not available, with preauthorization, the Plan will cover 100% of the charges for an Out-of-Network Provider and the Deductible will not apply. For preauthorization, please contact 800.493.0318 (TTY: 800.662.1220). | | |
| **Well Child Care and Immunizations from birth to age 19** | The recommendations of the United States Preventive Services Task Force will apply to exams and screenings; the recommendations of the Advisory Committee on Immunization Practices (ACIP) will apply to immunizations. | |
| | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Routine Newborn Care** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • Newborn Circumcision | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Routine Adult Care age 19 and older (Limited to one exam per Calendar Year)** | The recommendations of the United States Preventive Services Task Force will apply to exams and screenings; the recommendations of the Advisory Committee on Immunization Practices (ACIP) will apply to immunizations. | |
| • Related tests according to recommended age- appropriate guidelines are covered. | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • Routine hearing and vision exams are not covered under this section. | | |
| • Immunizations according to recommended age- appropriate guidelines are covered. | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Routine Colorectal Cancer Screening** for persons at (1) increased or high risk for developing colorectal cancer (based on specific personal or family health risk factors); or (2) average risk, beginning at age 45.<br>Benefit applies to all related Facility and Professional Provider charges. | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Routine Breast Cancer Screenings including Mammography and ultrasounds** (frequency based on age and family history - limited to one (1) screening per Calendar Year for age 35 and older; other screening criteria applies for high risk individuals) | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Routine Bone Mineral Density Measurement & Tests** (osteoporosis screening as recommended by a Professional Provider) | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Routine Annual Screening - Pelvic Exam, Cervical Cytology/ Pap Smear, and Related Tests for Covered Persons age 18 and older -** limited to (1) one screening per Calendar Year | The Plan covers 100% of the Allowed Charge. | Not covered. |

| **Preventive Care** | **SUOrange In-Network Benefits** (Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| ***Note:** If an In-Network Provider is not available, with preauthorization, the Plan will cover 100% of the charges for an Out-of-Network Provider and the Deductible will not apply. For preauthorization, please contact 800.493.0318 (TTY: 800.662.1220). | | |
| **Routine HPV-DNA screening** on recommendation from Professional Provider (FDA guidelines apply) | | |
| **Women's Preventive Services** include, but are not limited to, coverage for screening, counseling, and contraception management; see the Preventive Care, Well-Woman Preventive Services section for details. | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Routine Annual Prostate Cancer Screening** - limited to one (1) screening per Calendar Year, age 50 and above (other screening criteria applies for high risk individuals) | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Routine Vision Exam** (Limited to one (1) exam per 24-consecutive month period) | $35 Copayment, after Deductible for services rendered by a primary care physician or $50 Copayment, after Deductible for services rendered by a specialist. | Not covered. |
| **Routine Hearing Exam** (Limited to one (1) exam per 24-consecutive month period) | $35 Copayment, after Deductible for services rendered by a primary care physician or $50 Copayment, after Deductible for services rendered by a specialist. | Not covered. |
| **Nutritional/Dietary Counseling** (for adults with risk factors and both adults and children with obesity) | The Plan covers 100% of the Allowed Charge. | Not covered. |
| | Maximum of 26 visits per Covered Person per Calendar Year. Services must be rendered by a Professional Provider, certified nutritionist or certified or registered dietician. Recommendations of the US Preventive Services Task Force will apply. | |
| **Tobacco Use Cessation Counseling** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| | The recommendations of the US Preventive Services Task Force will apply. Tobacco cessation drugs and over-the-counter products are covered under the prescription drug benefit – a prescription is required. | |

| **Preventive Care** | **SUOrange In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| ***Note:** If an In-Network Provider is not available, with preauthorization, the Plan will cover 100% of the charges for an Out-of-Network Provider and the Deductible will not apply. For preauthorization, please contact 800.493.0318 (TTY: 800.662.1220). | | |
| **Genetic Counseling related to BRCA mutations** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| | The recommendations of the US Preventive Services Task Force will apply. | |
| **COVID-19 Vaccine**<br>Effective as of 15 business days after a recommendation is made from the US Prevention Services Task Force or CDC Advisory Committee on Immunization Practices | The Plan covers 100% of the Allowed Charge. | Not covered. |
| | The recommendations of the US Preventive Services Task Force or CDC Advisory Committee on Immunization Practices (as applicable) will apply. | |

| **Hospital and Other Facilities Expense Benefits** | **SUOrange In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Inpatient Care** (Facility charges)<br><br>Unlimited days<br><br>Room and board charges limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate, a Medically Necessary private room is covered.<br><br>Maternity care is covered the same as any other Illness. | $350 Copayment, after Deductible. | Not covered. |
| • **Nursery Care** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Certified Birthing Center**<br>(Facility charge and admission screening) | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Inpatient Mental Health Disorder Care** (Facility charge)<br>• Hospital or psychiatric Facility<br>• Residential care | $350 Copayment, after Deductible. | Not covered. |
| **Inpatient Substance Use Disorder Detoxification and Rehabilitation**<br>• Hospital or Substance Use Disorder Facility<br>• Residential care | $350 Copayment, after Deductible | Not covered. |

| **Hospital and Other Facilities Expense Benefits** | **SUOrange In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Outpatient Mental Health Disorder Care**<br>• Office visits | $35 Copayment, after Deductible. | Not covered. |
| • Other outpatient treatment (other than partial hospitalization) | $35 Copayment, after Deductible. | Not covered. |
| • Partial hospitalization (a separate Copayment applies if there is more than 90 consecutive days between the last service rendered under one treatment plan and the first service rendered under a new subsequent treatment plan) | $200 Copayment, after Deductible. | Not covered. |
| **Outpatient Treatment for Substance Use Disorders**<br>• Office visits | $35 Copayment, after Deductible. | Not covered. |
| • Other outpatient treatment (other than partial hospitalization) | $35 Copayment, after Deductible. | Not covered. |
| • Partial hospitalization (a separate Copayment applies if there is more than 90 consecutive days between the last service rendered under one treatment plan and the first service rendered under a new subsequent treatment plan) | $200 Copayment, after Deductible. | Not covered. |
| **Hospital Outpatient Care Services** | **Charges must be billed by the Hospital for its services and supplies. Professional Provider charges are considered separately. Only one Copayment is required per Covered Person for all Covered Services and Supplies for each Provider per service date.** | |
| • **Preadmission Testing** (Facility charge) | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • **Emergency Room** (Facility charge) – Emergency Medical Condition – Copayment is waived if Covered Person is admitted within 24 hours. | $150 Copayment, after Deductible. | $150 Copayment, after in-network Deductible. |
| • **Emergency Room** (Facility charge) – Non-Emergency Medical Condition | $150 Copayment, after Deductible. | $150 Copayment, after in-network Deductible. |
| • **Outpatient Surgery** (Facility charge) | $200 Copayment, after Deductible. | Not covered. |
| • **Radiation Therapy** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • **Chemotherapy** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • **IV Therapy** | The Plan covers 100% of the Allowed Charge. | Not covered. |

| **Hospital and Other Facilities Expense Benefits** | **SUOrange In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| • **Dialysis** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • **Physical Therapy** | $35 Copayment, after Deductible. | Not covered. |
| • **Respiratory Therapy** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • **Speech Therapy** | $35 Copayment, after Deductible. | Not covered. |
| • **Cardiac Rehabilitation**<br><br>Limited to a frequency of three (3) times per week and up to a maximum of 18 consecutive weeks for an approved plan of care | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • **Pulmonary Rehabilitation**<br><br>Limited to 36 visits per Covered Person per Lifetime | The Plan covers 100% of the Allowed Charge | Not covered. |
| • **Occupational Therapy** | $35 Copayment, after Deductible. | Not covered. |
| • **Diagnostic Breast Cancer Screenings including Mammography and ultrasounds** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • **Diagnostic X-rays and Radiology Services** (see MRI, PET, CT scans below) | $50 Copayment, after Deductible. | Not covered. |
| • **MRI, PET, CT scans** | $50 Copayment, after Deductible. | Not covered. |
| • **Diagnostic Laboratory Tests** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • **Diagnostic Machine Tests** | $50 Copayment, after Deductible. | Not covered. |
| • **Hospital Outpatient Clinic Visit** | $50 Copayment, after Deductible. | Not covered. |
| **Ambulance** | $100 Copayment, after Deductible. | $100 Copayment, after in-network Deductible. |
| **Ambulatory Surgical Center - Freestanding (Facility charge and preadmission testing)** | $150 Copayment, after Deductible. | Not covered. |

| **Hospital and Other Facilities Expense Benefits** | **SUOrange In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Inpatient Skilled Nursing Facility (SNF) / Rehabilitation Facility Care –** limited to 180 days per admission (or series of admissions)<br><br>An admission (or series of admissions) that is separated by more than 90 consecutive days is considered to be a separate admission. | $350 Copayment, after Deductible. | Not covered. |
| **Home Health Care**<br><br>Unlimited visits | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Hospice Care**<br><br>Inpatient and outpatient care are unlimited. Bereavement counseling is limited to five (5) visits per family any time prior to or after a person's death, per Calendar Year. | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Urgent Care Facility** | $50 Copayment, after Deductible. | Not covered. |

| **Medical/Surgical Services and Supplies**<br>(Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUOrange In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Surgical Charge Benefits**<br>• **Surgery** (Office and ambulatory surgery) | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • **Assistant Surgeon** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • **Anesthesia** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • **Maternity Care** (Physician charges only; Facility charges are covered separately) | The Plan covers 100% of the Allowed Charge. | Not covered. |
| • **Colonoscopy – Therapeutic** (Benefit applies to all related Facility and Professional Provider charges) | The Plan covers 100% of the Allowed Charge. | Not covered. |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUOrange In-Network Benefits** (Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **In-Hospital/Facility Physician's Care** (medical, mental health, and substance use disorders) | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Inpatient Specialist Consultation**<br><br>Limited to one (1) visit per day during a covered admission | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Office/Outpatient Specialist Consultation** (Professional Provider-requested) | $50 Copayment, after Deductible. | Not covered. |
| **Second Opinion** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Outpatient Provider Care**<br>Services and supplies must be given and billed by a covered healthcare provider in an office, clinic, home or elsewhere. | $35 Copayment, after Deductible if services are rendered by a Primary Care Physician or $50 Copayment, after Deductible if services are rendered by a specialist. | Not covered. |
| **Emergency Room Visit**<br>(Professional Provider's charge)<br><br>• Emergency Medical Condition | $50 Copayment, after Deductible. | $50 Copayment, after in-network Deductible. |
| • Non-Emergency Medical Condition | $50 Copayment, after Deductible. | $50 Copayment, after in-network Deductible. |
| **Diagnostic Breast Cancer Screenings including Mammography and ultrasounds** | The Plan covers 100% of the Allowed Charge. | Not covered. |
| **Diagnostic X-ray and Radiology Services**<br>(see MRI, PET, CT scans below)<br><br>• **MRI, PET, CT scans** | $50 Copayment, after Deductible. | Not covered. |
| • **Diagnostic Machine Tests** | $50 Copayment, after Deductible. | Not covered. |
| **Diagnostic Laboratory and Pathology Tests** (including independent laboratory) | The Plan pays 100% of the Allowed Charge. | Not covered. |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUOrange In-Network Benefits** (Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19**<br>Effective as of 03/13/2020 and during any portion of the emergency period defined in paragraph (1)(B) of the section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)). For purposes of this section the "emergency period" ends on 05/11/2023. | The Plan pays 100% of the Allowed Charge. | The Plan pays 100% of the Allowed Charge. |
| **Genetic Testing** | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Genetic Counseling** | $35 Copayment, after Deductible if services are rendered by a Primary Care Physician or $50 Copayment, after Deductible if services are rendered by a specialist. | Not covered. |
| **Allergy Testing and Treatment** (injections and treatment material) | $35 Copayment, after Deductible if services are rendered by a Primary Care Physician or $50 Copayment, after Deductible if services are rendered by a specialist. | Not covered. |
| **Allergy Serum** (billed separately from office visit) | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Professional Interpretation Charges** | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Dialysis** | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Clinical Trials** (excludes the actual Clinical Trial) | Covered - see specific expense type.<br>Only covers Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. Out-of-network coverage is only available if there is no In-Network Provider available. | Not covered. |
| **Radiation Therapy** | The Plan pays 100% of the Allowed Charge. | Not covered. |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUOrange In-Network Benefits** (Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **Chemotherapy** | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **IV Therapy** | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Outpatient Treatment for Mental Health Disorders**<br>• Psychological testing is covered | $35 Copayment, after Deductible. | Not covered. |
| **Outpatient Treatment for Substance Use Disorders** | $35 Copayment, after Deductible. | Not covered. |
| **Private Duty Nursing – Inpatient and Outpatient Care** | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Physical Therapy** | $35 Copayment, after Deductible. | Not covered. |
| **Speech Therapy** | $35 Copayment, after Deductible. | Not covered. |
| **Occupational Therapy** | $35 Copayment, after Deductible. | Not covered. |
| **Cardiac Rehabilitation**<br>Limited to a frequency of three (3) times per week and up to a maximum of 18 consecutive weeks for an approved plan of care | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Pulmonary Rehabilitation**<br>Limited to 36 visits per Covered Person per Lifetime | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Respiratory/Inhalation Therapy** | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Durable Medical Equipment** (other than oxygen and breastfeeding equipment) | 10% Coinsurance, after Deductible. | Not covered. |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUOrange In-Network Benefits** (Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| • Oxygen (to include equipment and supplies) | The Plan pays 100% of the Allowed Charge. | Not covered. |
| • Breastfeeding Equipment Rental or Purchase | The Plan pays 100% of the Allowed Charge. | Not covered. |
| | Limited to one (1) rental or purchase per pregnancy. Breast pumps are available out-of-network only if there is no In-Network Provider available, as determined by the Claims Administrator. The Medical Necessity requirement does not apply in-network or out-of-network. | |
| **Prosthetics** (external) | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Wigs** (for hair loss due to cancer treatment, burns, or systemic disease) | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **This is not an Essential Health Benefit** | Limited to $500 per Lifetime | |
| **Orthotics** (includes foot orthotics) | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Medical/Surgical Supplies** | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Therapeutic Injections** | $35 Copayment, after Deductible if services are rendered by a Primary Care Physician or $50 Copayment, after Deductible if services are rendered by a specialist. | Not covered. |
| **Contact Lens/Glasses for Certain Diagnostic Medical Conditions** Limited to one (1) pair each 24- consecutive month period | The Plan pays 100% of the Allowed Charge. | Not covered. |
| **Nutritional Therapy Other than Diabetes or Mental Health or Substance Use Disorders** - limited to eight (8) visits per Calendar Year with a registered or certified dietician | $50 Copayment, after Deductible. | Not covered. |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUOrange In-Network Benefits** (Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **Diabetic Supplies** | $30 Copayment, after Deductible. | Not covered. |
| **Diabetic Education** | $35 Copayment, after Deductible if services are rendered by a Primary Care Physician or $50 Copayment, after Deductible if services are rendered by a specialist. | Not covered. |
| **Diabetic Equipment** | $30 Copayment, after Deductible. | Not covered. |
| **Chiropractic Care** (including related X-rays) | $50 Copayment, after Deductible. | Not covered. |
| **Contraceptives administered or supplied in a Professional Provider's office** (prescription implants, injections, and devices only) | The Plan covers 100% of the Allowed Charge. Includes related physician medical care. | Not covered.. |
| **Acupuncture** | $50 Copayment, after Deductible. | Not covered. |
| **PUVA (Psoralen & Ultraviolet Light Therapy)** | $30 Copayment, after Deductible. | Not covered. |
| **Vision Therapy**<br>Medical Policy guidelines apply. For a copy of the Medical Policy visit www.excellusbcbs.com. | $30 Copayment, after Deductible. | Not covered. |
| **Nutritional Supplements for Phenylketonuria and Related Disorders, Enteral Formulas and Modified Food Products** | 10% Coinsurance, after Deductible. | Not covered. |
| **Blood Services** Autologous and **directed** donations are covered. | The Plan covers 100% of the Allowed Charge. | Not covered. |
| | Covered only when billed by a Facility or certified blood bank. | |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUOrange In-Network Benefits** (Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **Voluntary or Elective Sterilization**<br>• **Males** | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Not covered. |
| • **Females** | The Plan covers 100% of the Allowed Charge. Includes the Facility and Professional Provider charges. | Not covered. |
| **Voluntary or Elective Abortion** | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Not covered. |
| **Treatment of Morbid Obesity**<br>Medical Policy guidelines apply. For a copy of the Medical Policy visit www.excellusbcbs.com. | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Not covered. |
| **Dental Care** (due to accidental injury or congenital disease) | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Not covered. |
| **TMJ**<br>• **Medical related treatment** | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Not covered. |
| **TMJ**<br>• **Dental related treatment** | Not covered. | Not covered. |
| **Infertility**<br>**This is not an Essential Health Benefit** | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Not covered. |
| | Limited to $20,000 per Lifetime | |
| **Hearing Aids**<br>**This is not an Essential Health Benefit** | Deductible, then the Plan pays the lesser of 100% of the Allowed Charge or 50% of the Provider's charge up to a maximum of $750 for single hearing aid and $1,500 for binaural hearing aids. | Not covered. |
| | Limited to once every three (3) Calendar Years | |
| **Biofeedback** | $35 Copayment, after Deductible if services are rendered by a Primary Care Physician or $50 Copayment, after Deductible if services are rendered by a specialist. | Not covered. |

| **Medical/Surgical Services and Supplies** (Only one (1) Copayment is required per Covered Person for all Covered Services and Supplies for each Professional Provider per service date) | **SUOrange In-Network Benefits** (Subject to Allowed Charge) | **SUOrange Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **Radial Keratotomy** | Not covered. | Not covered. |
| **Telehealth**<br>Effective as of 03/16/2020 and through 09/30/2020 | | |
| MDLive providers | The Plan covers 100% of the Allowed Charge. | Not covered. |
| All other Providers | The Plan covers 100% of the Allowed Charge. | The Plan covers 100% of the Allowed Charge. |
| Effective as of 10/01/2020 | | |
| MDLive providers | Normal Plan cost-sharing based on type of service* | Not covered. |
| All other Providers | Normal Plan cost-sharing based on type of service* | Not covered* |
| | * except that for Telehealth related to the furnishing or administration of certain tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, coverage is as described in the section of this booklet titled “In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the Virus that causes COVID-19.” | * except that for Telehealth related to the furnishing or administration of certain tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, coverage is as described in the section of this booklet titled “In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the Virus that causes COVID-19.” Effective as of 05/12/2023, Telehealth related to related to the furnishing or administration of certain tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, is not covered. |
| **Transgender Services**<br>Medical Policy guidelines apply. For a copy of the Medical Policy visit www.excellusbcbs.com. | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Not covered. |

| SUOrange - Prescription Drugs | |
|---|---|
| **Annual Deductible** | No Deductible |
| **Out-of-Pocket Maximum** | $2,000 per individual with a maximum of $4,000 for a family |
| | |
| **Retail: Generic** | 20% Coinsurance* |
| **Retail: Brand Formulary** | 25% Coinsurance |
| **Retail: Brand Non-Formulary** | 45% Coinsurance |
| | |
| **Mail Order: Generic** | $20* |
| **Mail Order: Brand Formulary** | $50 |
| **Mail Order: Brand Non-Formulary** | $90 |
| | |
| **Specialty Mail Order (All)** | Same as Mail Order except 30 day supply |
| | |
| **Contraceptives** | Follows above schedule for retail and mail order |
| | |
| **Infertility Prescription Drugs** | Follows above schedule for retail and mail order |
| **This is not an Essential Health Benefit** | Limited to $20,000 per Lifetime |

*** Generic Prescription Drugs: $0 copay**
**Certain Age and other Restrictions Apply / Prescriptions are Required / Contact Optum Rx for more details at 866.854.2945 (TTY: 711)**

# APPENDIX C
# Schedule of Benefits – SUPro

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each Covered Service and Supply. Please refer to **Covered Services, Plan Exclusions,** and **Defined Terms**. In addition, the Plan's payments for Covered Out-of-Network Benefits described in the booklet section titled "**SPECIAL OUT-OF-NETWORK BENEFITS/PROTECTION AGAINST SURPRISE MEDICAL BILLS**" will be determined in accordance with the provisions of that section and may be different than the description in this Schedule.

| **Plan Features** | **SUPro In-Network Benefits** (Subject to Allowed Charge) | **SUPro Out-of-Network Benefits*** (Subject to Allowed Charge) |
|---|---|---|
| **Deductible per Calendar Year** | $200 per individual to a maximum of $400 per family | $300 per individual to a maximum of $1,000 per family |
| **Note:* In-network and out-of-network Deductibles aggregate separately. These Deductibles do not apply to Prescription Drug Benefits, or towards the Prescription Drug Out-of-Pocket Limit. Further, Prescription Drug Copayments and/or Coinsurance do not apply to the medical plan's Deductibles or the Out-of-Pocket Limit, as Prescription Drugs have a separate Out-of-Pocket Limit. | | |
| **Common Accident Deductible**<br>Only one (1) Deductible applies when two (2) or more covered family members are injured in the same accident. Only expenses due to that accident and applied against the Plan Deductible count toward this limit. Expenses also count toward the Calendar Year Deductible. | | |
| **Copayments**<br>Only one Copayment is required per Covered Person for all Covered Services and Supplies for each Provider per service date. | No Copayments are required for most Covered Services and Supplies. | No Copayments are required for most Covered Services and Supplies. |
| **Percentage Coinsurance** | The Covered Person pays 5% of the Allowed Charge for **inpatient hospitalization**, after the applicable Deductible; or the Covered Person pays 50% of the Allowed Charge for **hearing aids**, after the applicable Deductible; or the Covered Person pays 20% of the Allowed Charge for **all other Covered Services and Supplies**, after the applicable Deductible<br><br>See individual Plan features for details. | The Covered Person pays 5% of the Allowed Charge for **inpatient hospitalization**, after the applicable Deductible; or the Covered Person pays 50% of the Allowed Charge for **hearing aids**, after the applicable Deductible; or the Covered Person pays 30% of the Allowed Charge for **all other Covered Services and Supplies**, after the applicable Deductible<br><br>The Covered Person is also responsible for the difference between the Provider's actual charge and the Allowed Charge.<br><br>See individual Plan features for details. |
| **International Claims**<br>For Covered Persons receiving services in a foreign country, eligible claims will process as an In-Network Benefit, and a Covered Person is only responsible for the in-network Cost-Sharing. For claims incurred outside the Blue Cross Blue Shield Global Core Network, the Allowed Charge is based on the actual charge submitted. | | |

| | | |
|---|---|---|
| **Out-of-Pocket Limit per Calendar Year** (Coinsurance, Copayments and/or Deductibles apply to the Out-of-Pocket Limit) | $1,500 per person or $3,000 per family | $6,000 per person or $12,000 per family<br><br>The difference between the Provider's actual charge and the Allowed Charge does not count towards the Out-of-Pocket Limit. |
| **Note:* The in-network and out-of-network Out-of-Pocket Limits are cumulative across both levels. Copayments and/or Coinsurance for Prescription Drugs do not apply to the medical plan's Deductibles or towards the medical plan's Out-of-Pocket Limit. Similarly, medical plan Deductibles, Coinsurance and Copayments do not count towards the Prescription Drug plan's Out-of-Pocket Limit. | | |
| **Maximum Benefit Amounts (Lifetime)** | Unlimited, except for specific services that are not considered Essential Health Benefits. | |
| **Preauthorization** | For preauthorization contact 800-493-0318 (TTY: 800.662.1220). | |

| **Preventive Care** | **SUPro In-Network Benefits**<br><br>(Subject to Allowed Charge) | **SUPro Out-of-Network Benefits***<br><br>(Subject to Allowed Charge) |
|---|---|---|
| ****Note:*** If an In-Network Provider is not available, with preauthorization, the Plan will cover 100% of the charges for an Out-of-Network Provider and the Deductible will not apply. For preauthorization, please contact 800.493.0318 (TTY: 800.662.1220). | | |
| **Well Child Care and Immunizations from birth to age 19** | The recommendations of the United States Preventive Services Task Force will apply to exams and screenings; the recommendations of the Advisory Committee on Immunization Practices (ACIP) will apply to immunizations. | |
| | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Newborn Care** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • Newborn Circumcision | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Adult Care age 19 and older (Limited to one exam per Calendar Year)** | The recommendations of the United States Preventive Services Task Force will apply to exams and screenings; the recommendations of the Advisory Committee on Immunization Practices (ACIP) will apply to immunizations. | |
| • Related tests according to recommended age- appropriate guidelines are covered. | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • Immunizations according to recommended age- appropriate guidelines are covered. | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Colorectal Cancer Screening** for persons at (1) increased or high risk for developing colorectal cancer (based on specific personal or family health risk factors); or (2) average risk, beginning at age 45.<br><br>Benefit applies to all related Facility and Professional Provider charges. | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| Preventive Care | SUPro<br>In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro<br>Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| ***Note:** If an In-Network Provider is not available, with preauthorization, the Plan will cover 100% of the charges for an Out-of-Network Provider and the Deductible will not apply. For preauthorization, please contact 800.493.0318 (TTY: 800.662.1220). | | |
| **Routine Breast Cancer Screenings including Mammography and ultrasounds** (frequency based on age and family history - limited to one (1) screening per Calendar Year for age 35 and older; other screening criteria applies for high risk individuals) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Bone Mineral Density Measurement & Tests** (osteoporosis screening as recommended by a Professional Provider) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Annual Screening - Pelvic Exam, Cervical Cytology/ Pap Smear, and Related Tests for Covered Persons age 18 and older -** limited to (1) one screening per Calendar Year<br><br>**Routine HPV-DNA screening** on recommendation from Professional Provider (FDA guidelines apply) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Women's Preventive Services** include, but are not limited to, coverage for screening, counseling, and contraception management; see the Preventive Care, Well-Woman Preventive Services section for details. | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Annual Prostate Cancer Screening** - limited to one (1) screening per Calendar Year, age 50 and above (other screening criteria applies for high risk individuals) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Vision Exam**<br>(Limited to one (1) exam per 24-consecutive month period) | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Routine Hearing Exam** (Limited to one (1) exam per 24-consecutive month period) | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| Preventive Care | SUPro<br>In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro<br>Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| ***Note:** If an In-Network Provider is not available, with preauthorization, the Plan will cover 100% of the charges for an Out-of-Network Provider and the Deductible will not apply. For preauthorization, please contact 800.493.0318 (TTY: 800.662.1220). | | |
| **Nutritional/Dietary Counseling** (for adults with risk factors and both adults and children with obesity) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| | Maximum of 26 visits per Covered Person per Calendar Year. Services must be rendered by a Professional Provider, certified nutritionist or certified or registered dietician. Recommendations of the US Preventive Services Task Force will apply. | |
| **Tobacco Use Cessation Counseling** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| | The recommendations of the US Preventive Services Task Force will apply. Tobacco cessation drugs and over-the-counter products are covered under the prescription drug benefit – a prescription is required. | |
| **Genetic Counseling related to BRCA mutations** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| | The recommendations of the US Preventive Services Task Force will apply. | |
| **COVID-19 Vaccine**<br>Effective as of 15 business days after a recommendation is made from the US Prevention Services Task Force or CDC Advisory Committee on Immunization Practices | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| | The recommendations of the US Preventive Services Task Force or CDC Advisory Committee on Immunization Practices (as applicable) will apply. | |

| Hospital and Other Facilities Expense Benefits | SUPro<br>In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro<br>Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Inpatient Care** (Facility charges)<br><br>Room and board charges limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate.<br><br>Maternity care is covered the same as any other Illness. | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| Hospital and Other Facilities Expense Benefits | SUPro In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| • **Nursery Care** | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Certified Birthing Center** (Facility charge and admission screening) | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Inpatient Mental Health Disorder Care** (Facility charge)<br>• Hospital or psychiatric Facility<br>• Residential care | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Inpatient Substance Use Disorder Detoxification and Rehabilitation**<br>• Hospital or Substance Use Disorder Facility<br>• Residential care | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient Mental Health Disorder Care**<br>• Office visits | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • Other outpatient treatment | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • Partial hospitalization | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient Treatment for Substance Use Disorders**<br>• Office visits | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • Other outpatient treatment | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • Partial hospitalization | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Hospital Outpatient Care Services** | **Charges must be billed by the Hospital for its services and supplies. Professional Provider charges are considered separately. Only one Copayment is required per Covered Person for all Covered Services and Supplies for each Provider per service date.** | |
| • **Preadmission Testing** (Facility charge) | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Emergency Room** (Facility charge) – Emergency Medical Condition – Copayment is waived if Covered Person is admitted within 24 hours. | 20% Coinsurance, after Deductible. | 20% Coinsurance, after in-network Deductible. |
| • **Emergency Room** (Facility charge) – Non-Emergency Medical Condition | 20% Coinsurance, after Deductible. | 20% Coinsurance, after in-network Deductible. |

| Hospital and Other Facilities Expense Benefits | SUPro In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| • **Outpatient Surgery** (Facility charge) | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Radiation Therapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Chemotherapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **IV Therapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Dialysis** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Physical Therapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Respiratory Therapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Speech Therapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Cardiac Rehabilitation**<br><br>Limited to a frequency of three (3) times per week and up to a maximum of 18 consecutive weeks for an approved plan of care | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Pulmonary Rehabilitation**<br><br>Limited to 36 visits per Covered Person per Lifetime | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Occupational Therapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Diagnostic Breast Cancer Screenings including Mammography and ultrasounds** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Diagnostic X-rays and Radiology Services** (see MRI, PET, CT scans below) | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **MRI, PET, CT scans** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| Hospital and Other Facilities Expense Benefits | SUPro In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| • **Diagnostic Laboratory Tests** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Diagnostic Machine Tests** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Hospital Outpatient Clinic Visit** | 20% Coinsurance, after Deductible. | Deductible, $50 Copayment and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Ambulance** | 20% Coinsurance, after Deductible. | 20% Coinsurance, after in-network Deductible. |
| **Ambulatory Surgical Center - Freestanding (Facility charge and preadmission testing)** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Inpatient Skilled Nursing Facility (SNF)/Rehabilitation Facility Care –** limited to 180 days per admission (or series of admissions)<br><br>An admission (or series of admissions) that is separated by more than 90 consecutive days is considered to be a separate admission. | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Home Health Care**<br><br>Unlimited visits | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Hospice Care**<br><br>• **Inpatient**<br>Inpatient care is unlimited. | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Outpatient**<br>Outpatient care is unlimited.<br><br>Bereavement counseling is limited to five (5) visits per family any time prior to or after a person's death, per Calendar Year. | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Urgent Care Facility** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| Medical/Surgical Services and Supplies | SUPro In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Surgical Charge Benefits**<br>• **Surgery** | 5% Coinsurance, after | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| Medical/Surgical Services and Supplies | SUPro In-Network Benefits (Subject to Allowed Charge) | SUPro Out-of-Network Benefits* (Subject to Allowed Charge) |
|---|---|---|
| **Inpatient** | Deductible. | |
| **Outpatient** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Assistant Surgeon**<br>**Inpatient** | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Anesthesia**<br>**Inpatient** | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Maternity Care** (Physician charges only; Facility charges are covered separately)<br>**Inpatient** | The Plan covers 100% of the Allowed Charge. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient** | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Colonoscopy – Therapeutic** (Benefit applies to all related Facility and Professional Provider charges) | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **In-Hospital/Facility Physician's Care** (medical, mental health, and substance use disorders) | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Inpatient Specialist Consultation**<br>Limited to one (1) visit per day during a covered admission | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Office/Outpatient Specialist Consultation** (Professional Provider-requested) | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| Medical/Surgical Services and Supplies | SUPro In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Second Opinion** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient Provider Care**<br>Services and supplies must be given and billed by a covered healthcare in an office, clinic, home or elsewhere. | 20% Coinsurance, after Deductible. Exception: For prenatal and postnatal care the Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Emergency Room Visit**<br>(Professional Provider's charge)<br>• Emergency Medical Condition | 20% Coinsurance, after Deductible. | 20% Coinsurance, after in-network Deductible. |
| • Non-Emergency Medical Condition | 20% Coinsurance, after Deductible. | 20% Coinsurance, after in-network Deductible. |
| **Diagnostic Breast Cancer Screenings including Mammography and ultrasounds** | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Diagnostic X-ray and Radiology Services**<br>(see MRI, PET, CT scans below)<br>• **MRI, PET, CT scans** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| • **Diagnostic Machine Tests** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Diagnostic Laboratory and Pathology Tests** (including independent laboratory) | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19**<br><br>Effective as of 03/13/2020 and during any portion of the emergency period defined in paragraph (1)(B) of the section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)). For purposes of this section the "emergency period" ends on 05/11/2023. | The Plan pays 100% of the Allowed Charge. | The Plan pays 100% of the Allowed Charge. |
| **Genetic Testing** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| Medical/Surgical Services and Supplies | SUPro In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Genetic Counseling** | 20% Coinsurance, after Deductible.<br><br>Prenatal care: The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Allergy Testing and Treatment** (injections and treatment material) | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Allergy Serum** (billed separately from office visit) | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Professional Interpretation Charges**<br><br>**Inpatient** | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Dialysis** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Clinical Trials** (excludes the actual Clinical Trial) | Covered - see specific expense type. | Not covered. |
| | Only covers Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. Out-of-network coverage is only available if there is no In-Network Provider available. | |
| **Radiation Therapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Chemotherapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **IV Therapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient Treatment for Mental Health Disorders**<br>• Psychological testing is covered | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient Treatment for Substance Use Disorders** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| Medical/Surgical Services and Supplies | SUPro In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Private Duty Nursing – Inpatient and Outpatient Care**<br>**Inpatient** | 5% Coinsurance, after Deductible. | Deductible and 5% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Outpatient** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Physical Therapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Speech Therapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Occupational Therapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Cardiac Rehabilitation**<br><br>Limited to a frequency of three (3) times per week and up to a maximum of 18 consecutive weeks for an approved plan of care | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Pulmonary Rehabilitation**<br><br>Limited to 36 visits per Covered Person per Lifetime | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Respiratory/Inhalation Therapy** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Durable Medical Equipment** (other than oxygen and breastfeeding equipment)<br><br>• Oxygen (to include equipment and supplies) | 20% Coinsurance, after Deductible.<br><br>20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge.<br><br>Deductible and 30%Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| Medical/Surgical Services and Supplies | SUPro In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| • Breastfeeding Equipment Rental or Purchase | The Plan pays 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| | Limited to one (1) rental or purchase per pregnancy. Breast pumps are available out-of-network only if there is no In-Network Provider. The Medical Necessity requirement does not apply in-network or out-of-network. | |
| **Prosthetics** (external) | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Wigs** (for hair loss due to cancer treatment, burns, or systemic disease)<br><br>**This is not an Essential Health Benefit** | The Plan pays 100% of the Allowed Charge. | The Plan pays 100% of the Allowed Charge. You will be responsible for the difference between the actual charge and the Allowed Charge. |
| | Limited to $500 per Lifetime | |
| **Orthotics**<br>(includes foot orthotics) | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Medical/Surgical Supplies** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Therapeutic Injections** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Contact Lens/Glasses for Certain Diagnostic Medical Conditions**<br>Limited to one (1) pair each 24- consecutive month period | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Nutritional Therapy Other than Diabetes or Mental Health or Substance Use Disorders** - limited to eight (8) visits per Calendar Year with a registered or certified dietician | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Diabetic Supplies** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Diabetic Education** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |

| Medical/Surgical Services and Supplies | SUPro In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Diabetic Equipment** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Chiropractic Care** (including related X-rays) | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Contraceptives administered or supplied in a Professional Provider's office** (prescription implants, injections, and devices only) | The Plan covers 100% of the Allowed Charge. Includes related physician medical care. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge.<br><br>Related physician medical care is not included. It is a separate benefit. See the office visit benefit. |
| **Acupuncture** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **PUVA (Psoralen & Ultraviolet Light Therapy)** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Vision Therapy**<br><br>Medical Policy guidelines apply. For a copy of the Medical Policy visit www.excellusbcbs.com. | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Nutritional Supplements for Phenylketonuria and Related Disorders, Enteral Formulas and Modified Food Products** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Blood Services** Autologous and **directed** donations are covered. | The Plan covers 100% of the Allowed Charge. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| | Covered only when billed by a Facility or certified blood bank. | |
| **Voluntary or Elective Sterilization**<br><br>• **Males** | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |
| • **Females** | The Plan covers 100% of the Allowed Charge. Includes the Facility and Professional Provider charges. | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |

| Medical/Surgical Services and Supplies | SUPro In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Voluntary or Elective Abortion** | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |
| **Treatment of Morbid Obesity**<br>Medical Policy guidelines apply. For a copy of the Medical Policy visit www.excellusbcbs.com. | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |
| **Dental Care** (due to accidental injury or congenital disease) | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |
| **TMJ**<br>• **Medical related treatment** | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |
| • **Dental related treatment** | Not covered. | Not covered. |
| **Infertility**<br>**This is not an Essential Health Benefit** | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |
| | Limited to $20,000 per Lifetime | |
| **Hearing Aids**<br><br>**This is not an Essential Health Benefit** | Deductible, then the Plan pays the lesser of 100% of the Allowed Charge or 50% of the Provider's charge up to a maximum of $750 for single hearing aid and $1,500 for binaural hearing aids. | Deductible, then the Plan pays the lesser of 100% of the Allowed Charge or 50% of the Provider's charge up to a maximum of $750 for single hearing aid and $1,500 for binaural hearing aids. |
| | Limited to once every three (3) Calendar Years | |
| **Biofeedback** | 20% Coinsurance, after Deductible. | Deductible and 30% Coinsurance, plus the difference between the actual charge and the Allowed Charge. |
| **Radial Keratotomy** | Not covered. | Not covered. |

| Medical/Surgical Services and Supplies | SUPro In-Network Benefits<br><br>(Subject to Allowed Charge) | SUPro Out-of-Network Benefits*<br><br>(Subject to Allowed Charge) |
|---|---|---|
| **Telehealth**<br>Effective as of 03/16/2020 through 09/30/2020 | | |
| MDLive providers | The Plan covers 100% of the Allowed Charge. | Not covered. |
| All other Providers | The Plan covers 100% of the Allowed Charge. | The Plan covers 100% of the Allowed Charge. |
| Effective as of 10/01/2020 | | |
| MDLive providers | Normal Plan cost-sharing based on type of service* | Not covered. |
| All other Providers | Normal Plan cost-sharing based on type of service* | Normal Plan cost-sharing based on type of service* |
| | * except that for Telehealth related to the furnishing or administration of certain tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, coverage is as described in the section of this booklet titled "In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the Virus that causes COVID-19." | * except that for Telehealth related to the furnishing or administration of certain tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, coverage is as described in the section of this booklet titled "In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the Virus that causes COVID-19." |
| **Transgender Services**<br>Medical Policy guidelines apply. For a copy of the Medical Policy visit www.excellusbcbs.com. | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). | Covered – see specific expense type (for example, diagnostic tests, outpatient surgery, etc.). |

| SUPro - Prescription Drugs | |
|---|---|
| **Annual Deductible** | No Deductible |
| **Out-of-Pocket Maximum** | $2,000 per individual with a maximum of $4,000 for a family |
| | |
| **Retail Generic** | 15% Coinsurance* |
| **Retail Brand Formulary** | 25% Coinsurance |
| **Retail Brand Non-Formulary** | 40% Coinsurance |
| | |
| **Mail Generic** | Lesser of $15 or 15% Coinsurance* |
| **Mail Brand Formulary** | Lesser of $45 or 25% Coinsurance |
| **Mail Brand Non-Formulary** | Lesser of $90 or 40% Coinsurance |
| | |
| **Specialty Mail Order (All)** | Same as Mail Order except 30 day Supply |
| | |
| **Contraceptives** | Follows above schedule for retail and mail order |
| | |
| **Infertility Prescription Drugs** | Follows above schedule for retail and mail order |
| **This is not an Essential Health Benefit** | Limited to $20,000 per Lifetime |

***Generic Prescription Drugs: $0 copay**
**Certain Age and other Restrictions Apply / Prescriptions are Required /Contact Optum Rx at 866.854.2945 (TTY: 711) for further details**