univera
HEALTHCARE

This is your

RETIREE GROUP PRESCRIPTION DRUG PLAN
CERTIFICATE OF COVERAGE

Issued by

EXCELLUS HEALTH PLAN, INC.

doing business as
Univera Healthcare
205 Park Club Lane
Buffalo, NY 14221

To

Group contract holder

This Certificate of Coverage ("Certificate") explains the benefits available to you under a Group Contract between Excellus Health Plan, Inc. (hereinafter referred to as "we", "us", "our", or "the Plan") and the group contract holder listed in the Group Contract. This Certificate is not a contract between you and us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

This Certificate provides benefits for certain prescription drugs.

Important Notice: In order to be eligible for coverage under this Certificate, You must be enrolled in Medicare Part D through Excellus Health Plan. This Certificate covers amounts that are payable after your Medicare Part D plan has paid and after any applicable discounts have been applied.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

EXCELLUS HEALTH PLAN, INC.
doing business as

Univera Healthcare
205 Park Club Lane
Buffalo, NY 14221

By: Christopher C. Booth

Christopher C. Booth
President and Chief Executive Officer

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SECTION ONE - INTRODUCTION AND DEFINITIONS

1. **Your Coverage under This Certificate.** Your employer or organization (referred to as the "group contract holder") has purchased a group health insurance contract from us. Under that contract we will provide the benefits described in this Certificate to members of the group, that is, to employees or retirees of the employer or to members of the organization. However, this Certificate is not a contract between you and us. You should keep this Certificate with your other important papers so that it is available for your future reference.

2. **Definitions.**

   A. **Brand Name Drug.** A Prescription Drug that is manufactured, approved and marketing under a New Drug Application (NDA).

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

   C. **Coinsurance.** A charge, expressed as a percentage of the lesser of the Negotiated Rate or the Participating Pharmacy's charge,that you must pay for Prescription Drugs covered under this Certificate that are dispensed by a Participating retail or specialty Pharmacy.

   D. **Copayment.** A charge, expressed as a fixed dollar amount, that you must pay for the dispensing of a Prescription Drug, before we will make any payments under this Certificate.

   E. **Deductible.** A charge, expressed as a fixed dollar amount, that you must pay once each Year before we will pay anything for Prescription Drugs covered under this Certificate during that Year.

   F. **Effective Date.** The date your coverage under this Certificate begins. Coverage begins at 12:01 a.m. on the Effective Date.

   G. **Emergency Condition.** A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

      (2) Serious impairment to such person's bodily functions;

      (3) Serious dysfunction of any bodily organ or part of such person; or

      (4) Serious disfigurement of such person.

      Examples of medical conditions that we consider to be Emergency Conditions are heart attacks, poisoning and multipletrauma.

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

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

   I. **Enrollment Area.** You must live, work or reside, or be a retiree of a Group located, in one of the following counties in order to be covered under this Certificate: Allegany; Cattaraugus; Chautauqua; Erie; Niagara; Genesee; Orleans.

J. **Facility.** A Hospital; ambulatory surgery facility; birthing center; dialysis center; rehabilitation facility; skilled nursing facility; hospice; home health agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; an 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; an institutional provider of chemical dependence and abuse treatment certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"); other provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable); or an independent clinical laboratory. If you receive treatment for chemical dependence or abuse outside of New York State, the Facility must have an operating certificate issued by a licensing authority comparable to OASAS and must also be accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), or a similar national organization, to provide the treatment.

K. **Generic Drug.** A Prescription Drug that is manufactured, approved, and marketed under an Abbreviated New Drug Application (ANDA).

L. **Hospital.** Any short-term acute general hospital facility that is accredited as a hospital by JCAHO; is certified under Medicare; and if located in New York State, is licensed pursuant to Article 28 of the Public Health Law of New York. A Hospital is a licensed institution primarily engaged in providing:

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

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

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

None of the following are considered Hospitals:

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

(2) Places primarily for nursing care;

(3) Skilled Nursing Facilities;

(4) Convalescent homes or similar institutions;

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

(6) Health resorts; spas; or sanitariums;

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

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

(9) Free standing ambulatory surgical centers.

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

N. **Medical Necessity.** See Section Three

O. **Member.** Any Subscriber who meets all applicable eligibility requirements, for whom the required premium payment has actually been received by us, and who is covered under this Certificate.

P. **Negotiated Rate.** The rate of payment agreed to between the Participating Pharmacy and us for Prescription Drugs covered under this Certificate.

Q. **Non-Participating Pharmacy.** Any Pharmacy that dispenses Prescription Drugs and has not entered into a participation agreement with us. We will not pay any benefits under this Certificate for Prescription Drugs you purchase at a Non-Participating Pharmacy.

R. **Participating Pharmacy.** Any pharmacy that regularly dispenses Prescription Drugs and has entered into a participation agreement with us.

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

Prescription Drugs shall include Medically Necessary enteral formulas for which an authorized provider has issued a written order. The written order must state that the enteral formula is clearly Medically Necessary and has been proven effective as a disease-specific method of treatment for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated. We will also pay for modified solid food products for the treatment of certain inherited diseases of amino acid or organic acid metabolism, when provided pursuant to such written order. The tier designation(s) that apply to modified solid food products are identified on the formulary that is available on our website at www.myuniveramedicare.com, or that will be mailed to you upon request. You may request the formulary by calling the number shown on your ID card.

Prescription Drugs include drugs and devices, or their generic equivalents, approved by the FDA for treatment of osteoporosis. We will apply our standards and guidelines that are consistent with the criteria of the federal Medicare program or the National Institutes of Health ("NIH") to determine appropriate coverage for treatment of osteoporosis under this Rider. We will provide coverage for drugs and devices covered under Medicare or consistent with the NIH criteria. When consistent with the Medicare or NIH criteria, coverage, at a minimum, will be provided for those Members:

(1) Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(2) With symptoms or conditions indicative of the presence, or a significant risk, of osteoporosis; or

(3) On a prescribed drug regimen posing a significant risk of osteoporosis; or

(4) With lifestyle factors to the degree of posing a significant risk of osteoporosis; or

(5) With such age, gender and/or physiological characteristics that pose a significant risk of osteoporosis.

T. **Service Area.** The geographic area in which we will arrange or provide benefits to our Members. Our Service Area consists of the following counties: Allegany; Cattaraugus; Chautauqua; Erie; Niagara; Genesee; and Orleans.

U. **Subscriber.** The member of the group to whom this Certificate is issued.

V. **"We", "Us", "Our" or "The Plan" and "You", "Your" and "Yours".** Throughout this Certificate,Univera Healthcare. will be referred to as "we", "us", "our" or "the Plan". The word "you", "your" or "yours" refers to you, the Subscriber. If other than individual coverage applies, then in most cases the word "you" also includes any family members who are covered under this Certificate.

W. **Year.** The 12-month period on which the annual limits under this Certificate are based. Unless otherwise indicated, that 12-month period is the Calendar Year as defined above.

SECTION TWO - WHO IS COVERED

1. **Who Is Covered under This Certificate.** Subject to the permissible eligibility rules of the group contract holder, you, the Subscriber to whom this Certificate is issued, are covered under this Certificate. You must be enrolled in Medicare Part D coverage through Excellus Health Plan in order to be covered under this Certificate.

2. **Persons Not Covered.** Individuals who do not either live, reside or work in our Enrollment Area or who are not retirees of a Group located in our Enrollment Area are not covered under this Certificate. Individuals who are not also covered by Medicare Part D coverage are not covered under this Certificate.

3. **When Coverage Begins.** Coverage under this Certificate will begin as follows:

   A. If you, the Subscriber, elect coverage before becoming eligible for coverage or within 30; days of becoming eligible, coverage begins at 12:01 a.m. on the date you become eligible.

   B. If you, the Subscriber, do not elect coverage upon becoming eligible or within 30; days of becoming eligible, you must wait until the group's next open enrollment period, except as provided in Paragraph 4 below. When you enroll during the next open enrollment period, coverage then begins at 12:01 a.m. on the date to which the open enrollment period applies.

4.. **When You Reject Initial Enrollment Or Elect Not To Enroll During Open Enrollment, But Do Not Need To Wait Until The Group's Next Open Enrollment Period To Enroll For Coverage.** If you, the Subscriber, reject initial enrollment under this Certificate, or elect not to enroll during a subsequent open enrollment, you may enroll for coverage if the following conditions are met:

   A. You had coverage under another plan or contract when coverage was initially offered or at a subsequent open enrollment period; and

   B. Coverage was provided in accordance with continuation required by state or federal law and was exhausted; or coverage under the other plan or contract was terminated because you or your dependent lost eligibility for one or more of the following reasons:

      (1) Termination of employment;

      (2) Termination of the other plan or contract;

      (3) Death of the spouse;

      (4) Legal separation, divorce or annulment;

      (5) Reduction in the number of hours worked;

      (6) The employer or other group ceased its contribution toward the premium for the other plan or contract;

      (7) The coverage was under an HMO, and you no longer live, work or reside in the HMO service area;

      (8) Cessation of dependent child status;

      (9) Benefits are no longer offered to similarly situated individuals (e.g., part-time employees);

      (10) The benefit maximum under the plan or contract has been reached;

   C. You apply for coverage under this Certificate within 60 days after termination for one of the reasons set forth in Subparagraph B above.

   D. In addition to the reasons set forth in Subparagraph A, and B , above, you may apply for coverage under this Certificate upon enrollment in Medicare Part D coverage through Excellus Health Plan..

   If you enroll for coverage pursuant to Subparagraphs A, B and D, , your coverage will begin at 12:01 a.m. on the first day of the month following the request for enrollment.

SECTION THREE - MEDICAL NECESSITY AND PRIOR AUTHORIZATION

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

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

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

   A. Reports in peer reviewed medical literature;

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

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

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

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

   F. Any other relevant information brought to our attention.

   Services will be deemed Medically Necessary only if:

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

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

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

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

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

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

2. **Service Must Be Approved Standard Treatment.** Except as otherwise required by law, no Service rendered to you will be considered Medically Necessary unless we determine 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. Please see Section Nine, paragraph 29 for your right to an external appeal of our determination that a Service is not Medically Necessary.

3. **Services Subject To Prior Authorization.** We will periodically identify certain Prescription Drugs that, for reasons such as cost, patient safety, and possible use for purposes that are not Medically Necessary or appropriate, will only be filled with prior authorization from us. The Prescription Drugs that require prior authorization are identified on the formulary that is available on our website at www.myuniveramedicare.com or that will be mailed to you upon request. You may request the formulary by calling the number shown on your ID card. The Prescription Drugs that require prior authorization may change. We therefore encourage you to call us or consult the formulary to determine if prior authorization is required for a specific drug so that you can avoid any benefit reduction that will apply if you fail to comply with the prior authorization requirement.

4. **Prior Authorization Procedure.** If you seek coverage for a Prescription Drug that requires prior authorization, you initiate the prior authorization procedure by calling the number on your ID card; and your provider must submit a statement of Medical Necessity to us. After receiving a request for prior authorization, we will review the statement of Medical Necessity and determine if benefits are available. We will notify you and your Professional Provider of our decision by telephone and in writing within three business days of receipt of all necessary information.

   With respect to an urgent request for prior authorization, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your Professional Provider, by telephone and in writing, within 72 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour period. A request is "urgent" if it could seriously jeopardize your life or health or the ability to regain maximum function; or if your provider determines that it is urgent, we must treat it as such.

5. **Your Right to Appeal.** If you or your Professional Provider disagrees with our decision, you may appeal by following the procedures set forth in Section Nine, paragraph 27. Any written appeals must be made to: P.O. Box 4717, Syracuse, NY 13221.

6. **Failure to Seek Authorization.** When you fail to seek our prior authorization of a Prescription Drug that requires such authorization and the drug is dispensed, you must pay the Participating Pharmacy the total cost of the drug. If you then submit a claim to us, we will pay the claim in accordance to your Part D contract. We will reimburse up to the pharmacy contracted rate, minus the Part D copay/coinsurance. We will only pay this amount if we determine the Prescription Drug was Medically Necessary, even though you did not seek our prior authorization. If we determine that the Prescription Drug was not Medically Necessary, we will not make any payment for the drug; and you will be responsible for the entire charge.

SECTION FOUR - COST-SHARING EXPENSES

1. **Copayments.** The Copayments you must pay for covered Benefits are set forth on the Schedule of Benefits.

2. **Deductible.** A charge, expressed as a fixed dollar amount, that you must pay once each Year before we will pay anything for Prescription Drugs covered under this Certificate during that Year. (See Schedule of Benefits for any applicable deductible for your plan.)

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

4. **Cost of Drug is Less Than Cost Share.** If the usual and customary cost of the covered Prescription Drug is less than the Copayment applied to the Drug, then You are responsible only for the cost of the Prescription Drug.

SECTION FIVE - PRESCRIPTION DRUG BENEFITS

1. **Pharmacy Benefits Provided.**

   A. **Integration with Medicare Part D.** Medicare Part D has various levels or stages of coverage. Coverage under this Certificate depends on which level or stage of Medicare Part D You are at when you submit a claim. These levels or stages are as follow:

      1. **Yearly Deductible.** This is the amount that You must pay each year for your Prescription Drugs before you Medicare Part D plan begins to pay its share of your covered Drugs. (See Schedule of Benefits for any applicable deductible.)

      2. **Initial Coverage Stage (Copayment/Coinsurance—Level).** This is the Copayment or Coinsurance amount that You pay for each prescription after You have paid the Deductible.

3. **Coverage Gap or "Donut Hole".** This is the limit on what Your Medicare Part D plan will cover.

   When you enter the Coverage Gap or "Donut Hole", this Certificate will cover drugs that are covered by Your Part D plan.

4. **Catastrophic Coverage.** This is the coverage that You get under your Medicare Part D plan when you move out of the Coverage Gap or "Donut Hole."

You will pay a Participating Pharmacy the least of the applicable Copayment, Coinsurance, Negotiated Rate or the Pharmacy's usual charge for the Drug, up to the cost share applied during the Initial Coverage Period. .

B. **Drugs from a Participating Retail or Specialty Pharmacy.** If you have a prescription filled at a Participating retail or specialty Pharmacy, you must pay the pharmacy the applicable Copayment or Coinsurance for each separate prescription or refill for the Prescription Drug. The pharmacy will be paid directly by us for the remainder of the cost of the prescription or refill.

C. **Drugs from a Participating Mail Service Pharmacy.**

(1) If you have a prescription filled with a Generic Drug, you must pay the pharmacy either a Copayment or Coinsurance per each 30-day supply or the cost of the Generic Drug, whichever is less, for each separate prescription or refill for that Generic Drug. The pharmacy will be paid directly by us for the remainder of the cost of the prescription or refill.

(2) If you have a prescription filled with a Brand Name Drug, you must pay the pharmacy either a Copayment or Coinsurance for each 30-day supply or the cost of the Brand Name Drug, whichever is less, for each separate prescription or refill for that Brand Name Drug. The pharmacy will be paid directly by us for the remainder of the cost of the prescription or refill.

(3) You may fill any Prescription Drug that may be obtained through a Participating Mail Service Pharmacy at a Participating non-mail service retail pharmacy provided that the Participating non-mail order retail pharmacy agrees with Us in advance to the same reimbursement amount and the same terms and conditions that We have established for the participating Mail Service Pharmacy.

D. **Drugs from a Non-Participating Pharmacy. We will not pay for any benefits under this Certificate for drugs that you purchase at a Non-Participating Pharmacy.**

2. **Limitations.**

A. **Step Therapy Program.** The Step Therapy Program is a form of prior authorization under which certain Prescription Drugs require prior authorization if a Generic Drug or cost-effective alternative Prescription Drug has not been tried. The Prescription Drugs that require prior authorization under the Step Therapy Program are identified on the formulary that is available on our website at www.myuniveramedicare.com, or that will be mailed to you upon request. You may request the formulary by calling the number shown on your ID card.

B. **Prescription Drugs that Receive FDA Approval.** Prior authorization or step therapy applies to all new drugs entering the market upon FDA approval. The new drugs will be added to our Prior Authorization and Step Therapy Drug List until we determine that the new drug satisfies our criteria for safety, efficacy and cost-effectiveness.

C. **Other Changes.** We may add or change prior authorization or step therapy requirements: on a Brand Name Drug when a therapeutically equivalent Generic Drug becomes available; or to promote safe utilization of a Prescription Drug based on new clinical guidelines or information related to drug safety and effectiveness. These changes will be made following notice to affected Members.

D. **Supply.** We will pay for no more than a 90 or 102-day supply of a drug purchased at a Participating retail or specialty Pharmacy. Benefits will be provided for drugs dispensed by a Participating mail service Pharmacy in a quantity of up to a 90-day supply; and you are responsible for your Copayment

for up to a 90 or 102-day supply. The limitations in this subparagraph are subject to our right to establish quantity limits as described in Subparagraph E below. (See Schedule of Benefits for applicable day supply and cost share for your plan.)

Notwithstanding anything to the contrary set forth above in this Subparagraph B, we will provide the benefits that apply to drugs dispensed by a Participating mail service Pharmacy to drugs purchased from a Participating retail Pharmacy when that pharmacy has a participation agreement with us in which it agrees to be bound by the same terms and conditions as a Participating mail service Pharmacy.

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

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

G. **Early Refills of Prescription Eye Drops.** Notwithstanding anything to the contrary set forth above, we will provide coverage for a limited refill of prescription eye drops prior to the last day of the dosage period. To the extent practicable, the quantity of eye drops in the early refill will be limited to the amount remaining on the dosage that was initially dispensed. Your cost sharing for the limited refill is the amount that applies to each prescription or refill as set forth above.

H. **Compounded Prescription Drugs.** Compounded Prescription Drugs will be covered only when they contain at least one ingredient that is a covered legend Prescription Drug, are Medically Necessary, and are obtained from a Participating Pharmacy that is approved for compounding. All compounded Prescription Drugs require prior authorization.

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

J. Various specific and/or generalized "use management" protocols will be used from time-to-time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide our Members with a quality-focused drug benefit. In the event a use management protocol is implemented, and you are taking the drug(s) affected by the protocol, you will be notified in advance.

5. **General Conditions.**

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

B. As a condition precedent to the approval of claims hereunder, each Member authorizes and directs any Participating Pharmacy that furnishes benefits hereunder to make available to us information relating to all prescription orders, copies thereof and other records as needed by us for purposes of administering this Certificate. In every case we will hold such information and records as confidential.

C. Drug Utilization, Cost Management and Rebates. We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, your group and its Members benefit by obtaining appropriate Prescription Drugs in a cost-effective manner.

The cost savings resulting from these activities are reflected in the premiums for your coverage. We may, from time-to-time, also enter into agreements that result in us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drug products across all of our business and not solely on any one Member's or one group's utilization of Prescription Drugs. Any rebates received by us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of our Prescription Drug premiums. Instead, any such rebates may be retained by us, at our discretion, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of subscribers. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under our Prescription Drug coverage.

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

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

SECTION SIX - EXCLUSIONS

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

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

   B. Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name as their prescription counterparts.

   C. Devices of any type, even though a prescription may be required.

   D. Vitamins, or any herbal product, except those that require a prescription by law and have been approved by the FDA under the NDA or ANDA process.

   E. Drugs that are prescribed or dispensed for cosmetic purposes and are not Medically Necessary. Examples of the kinds of drugs that we often determine to be not Medically Necessary include those prescribed or dispensed for hair growth or removing wrinkles.

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

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

   H. Most drugs given or administered in a physician's office or in an inpatient or outpatient Facility.

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

   J. Fertility drugs relating to the following infertility treatment services: in vitro fertilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); reversal of elective sterilizations, including vasectomies and tubal ligations; sex change procedures; cloning; and other procedures or categories of procedures excluded by statute.

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

(1) The service or care would be covered under this Certificate in the absence of a court order;

(2) Our procedures have been followed to authorize the service or care; and

(3) The Medical Director determines, in advance, that the service or care is Medically Necessary and covered under the terms of this Certificate.

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

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

M. We will not provide coverage for any service or care for treatment of the teeth, gums, or structures supporting the teeth; or any form of dental surgery; regardless of the reasons(s) that the service or care is necessary. We will, however, provide the benefits set forth in this Certificate for service and care for treatment of sound natural teeth provided within 12 months of an accidental injury. We do not consider an injury to a tooth caused by chewing or biting to be an accidental injury. We will also provide coverage for the services set forth in this Certificate that we determine are Medically Necessary for treatment of a congenital anomaly or disease that was present at birth, such as cleft palate and ectodermal dysplasia.

N. Experimental and Investigational Services. Unless otherwise required by law, we will not provide coverage for any drug, biological product or device (collectively, "Service"); if we determine that the Service is experimental or investigational. See Section Nine, paragraph 29 for your right to an external appeal of our determination that a Service is experimental or investigational.

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

(1) Not of proven benefit for a particular diagnosis or for treatment of a particular condition;

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

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

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

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

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

(2) Published, peer-reviewed, medical literature must provide conclusive evidence that the Service has a definite, positive effect on health outcomes. The evidence must include reports of well-designed investigations that have been reproduced by nonaffiliated, authoritative sources with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

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

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

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

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

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

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

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

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

S. Prohibited Referral. We will not provide coverage for any pharmacy, clinical laboratory, radiation therapy, physical therapy, x-ray, or imaging services that were provided pursuant to a referral prohibited by the New York Public Health Law.

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

(1) Prior to the Effective Date of your coverage under this Certificate; or

(2) On or after the Effective Date of your coverage under this Certificate, if that service or care is covered under a provision in any other health benefits contract, program or plan that extends benefits when you are totally disabled on the date coverage under the other contract, program or plan ends.

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

V. Workers' Compensation. We will not provide coverage for any service or care for which benefits are provided under a workers' compensation or similar law.

SECTION SEVEN - COORDINATION OF BENEFITS

This section applies only if you also have other group health benefits coverage with another plan.

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

   A. Any group or blanket insurance contract, plan or policy, including HMO and other prepaid group coverage, except that blanket school accident coverage or such coverage offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;

   B. Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;

   C. Any Blue Cross, Blue Shield, or other service type group plan;

   D. Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and

   E. Medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional "fault" type contracts.

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

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

   B. If you are covered under one plan as an employee, subscriber or member and you are only covered as a dependent under the other plan, the plan which covers you as an employee will be primary; or

   C. Subject to the provisions regarding separated or unmarried parents below, if you are covered as a child under both plans, the plan of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the plan that covered the parent longer is primary. If the other plan does not have the rule described immediately above, but instead has a rule based on gender of a parent and, as a result, the plans do not agree on which shall be primary, then the father's plan will be primary.

There are special rules for a child of separated or unmarried parents:

(1) If the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.

(2) If no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with custody of the child;

(c) Finally, the plan of the parent not having custody of the child.

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

E. If none of the above rules determine which plan shall be primary, then the plan that has covered you for the longest time will be primary.

3. **Payment of the Benefit When This Plan Is Secondary.** When this plan is secondary, the benefits of this plan will be reduced so that the total benefits payable under the other plan and this plan do not exceed your expenses for an item of service. However, we will not pay more than we would have paid if we were primary.

   We count as actually paid by the primary plan any items of expense that would have been paid if you had made the proper and timely claim. We will request information from that plan so we can process your claims. If the primary plan does not respond within 30 days, we will assume its benefits are the same as ours. If the primary plan sends the information after 30 days, we will adjust our payment, if necessary.

   Although it is not a requirement of this section, when you have coverage under more than one health plan, you can help to maximize the benefits available to you by following the rules and protocols of both the primary and secondary plans.

4. **Right to Receive and Release Necessary Information.** We have the right to release or obtain information that we believe necessary to carry out the purpose of this section. We need not tell you or obtain anyone's consent to do this except as required by Article 25 of the New York General Business Law. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information that we request. If you do not furnish the information to us, we have the right to deny payments.

5. **Payments to Others.** We may repay to any other person, insurance company or organization the amount which it paid for your covered services and which we decide we should have paid. These payments are the same as benefits paid.

6. **Our Right to Recover Overpayment.** In some cases we may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other plan. You must sign any document that we deem necessary to help us recover any overpayment.

SECTION EIGHT - TERMINATION OF YOUR COVERAGE

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

1. **Termination of the Group Contract.** This Certificate is provided under the terms of the Group Contract between us and the group contract holder. The Group Contract is effective for one year and will automatically be renewed each year unless it is terminated as set forth below.

   A. The group contract holder terminates the Group Contract pursuant to its terms. In this case, your coverage will terminate on the date the group contract holder terminates;

   B. We do not receive premium payment from the group contract holder as of the date the premium was due. In this case, your coverage will end on the date to which the premium has been paid;

   C. The group contract holder has committed fraud or made an intentional misrepresentation of material fact under the terms of the Group Contract. In this case, your coverage will terminate 30 days from the date we provide notice to you;

   D. The group contract holder no longer qualifies as a group. We have certain administrative rules that describe our requirements for group contract holders. Our rules are consistent with New York State law and regulations governing health insurance. If you have a question about the rules that apply to your group contract holder, you may contact us and we will explain them to you.

      When your group contract holder no longer meets our requirements, we will notify you. Your coverage will terminate 30 days from the date we provide notice to you;

   E. The group contract holder fails to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under section 4235 of the Insurance Law. In this case, your coverage will terminate 30 days from the date we provide notice to you;

   F. The group contract holder no longer has any enrollee living, residing or working in New York State. In this case, your coverage will terminate 30 days from the date we provide notice to you;

   G. Any reason approved by the New York State Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act. In this case, your coverage will terminate 30 days from the date we provide notice to you;

   H. If we terminate the entire class of contracts to which this Certificate belongs. In this case, your coverage will terminate 90 days from the date we provide notice to you; or

   I. If we withdraw from the applicable market through which you obtained coverage under this Certificate, and we cease offering any products in that market. In this case, your coverage will terminate 180 days from the date we provide notice to you.

2. **Termination of Your Coverage under This Certificate.** In the following instances, the Group Contract will continue in force, but your coverage under this Certificate will be terminated:

   A. You choose to terminate your coverage. You must give the group contract holder 30 days' written notice. Your coverage will terminate on the date to which your premium is paid;

   B. You are no longer a member of the group. Your coverage will terminate on the date to which your premium is paid if you are no longer a member of the group;

   C. You committed fraud in applying for coverage or in filing a claim under this Certificate. Your coverage will terminate 30 days from the date we provide notice to you;

   D. Any reason approved by the Superintendent of Insurance. In this case, your coverage will terminate 30 days from the date we provide notice to you. A copy of the reason for the termination of your coverage will be provided to you upon request;

E. On your death. Your coverage under this Certificate will automatically terminate on the date after your death or the death of the Subscriber;

F. You are no longer covered under Medicare Part D .

3. **Coverage Options Following Termination of Your Coverage.** If your coverage under this Certificate terminates, You may be entitled to coverage under Your employer group's primary Part D plan or under an individual Medicare Part D plan.

SECTION NINE - GENERAL PROVISIONS

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

2. **Notice.** Any notice that we give to you under this Certificate will be mailed to your address as it appears on our records or to the address of the group contract holder. If you have to give us any notice, it should be mailed to: 205 Park Club Lane, Buffalo, NY 14221.

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

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

4. **Who Receives Payment under This Certificate.** Payments under this Certificate for service provided by a Participating Pharmacy will be made directly by us to the provider.

5. **Time to File Claims.** Claims for services under this Certificate must be submitted to us for payment within 12 months after you receive the services for which payment is being requested.

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

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

8. **Choice of Law.** This Certificate shall be governed by the laws of the State of New York.

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

10. **Right to Offset.** If we make a claim payment to you or on your behalf in error or you owe us any money, you must repay the amount you owed to us. If we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we owe you.
11. **Subrogation.** To the extent permitted by law, in the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and we pay benefits as a result of that injury or illness, we will be subrogated and succeed to the right of recovery against the party responsible for your illness or injury to the extent of the benefits we have paid.
12. **Who May Change This Certificate.** The Certificate may not be modified; amended; or changed, except in writing, and signed by our Chief Operating Officer (COO) or a person designated by the COO. No employee; agent; or other person is authorized to interpret; amend; modify; or otherwise change the Certificate in a manner that expands or limits the scope of coverage; or the conditions of eligibility; enrollment; or participation, unless in writing and signed by the COO or person designated by the COO.
13. **Changes in This Certificate.** We may unilaterally change this Certificate upon the group's renewal, if we give the group contract holder 44 days' prior written notice.
14. **Renewal Date. The renewal date for the Certificate is January 1st of each Year.** This Certificate will automatically renew each year on the renewal date unless otherwise terminated by us or the group contract holder as permitted by the Certificate or by you upon 30 days' prior written notice to the group contract holder.
15. **Agreements between the Plan and Participating Providers.** Any agreement between us and Participating Providers may only be terminated by us or the providers. This Certificate does not require any provider to accept a Member as a patient.
16. **Material Accessibility.** We will give the group contract holder, and the group contract holder will give Members, identification cards, Certificates, Riders and other necessary materials.
17. **Refund.** We will give any refund of premiums, if due, to the group contract holder.
18. **Notice of Claim.** Claims for services under this Certificate must include all information designated by us as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, social security number, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information.
19. **Identification Cards.** Identification cards are issued by us for identification only. Possession of any identification card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits the Member's premiums must be paid in full at the time that the services are sought to be received. Coverage under this Certificate may be terminated by us if the Member allows another person to wrongfully use the identification cards.
20. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when we will make or will not make payments under this Certificate. 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 Certificate. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Certificate.

21. **Furnishing Information and Audit.** The group contract holder and all persons covered under this Certificate will promptly furnish us with all information and records that we may require from time to time to perform our obligations under this Certificate. You must provide us with information over the telephone for reasons like the following: to allow us to determine the level of care you need; so that we may certify care authorized by your physician; or to make decisions regarding the Medical Necessity of your care. The group contract holder will, upon reasonable notice, make available to us, and we may audit and make copies of, any and all records relating to group enrollment at the group contract holder's New York office.

22. **Enrollment; ERISA.** The group contract holder 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 Certificate, and any other information required to confirm their eligibility for coverage. The group contract holder will provide us with the enrollment form including your name, address, age, and social security number and to advise us in writing when you are to be added to or subtracted from our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date the group's contract with us. If the group contract holder fails to so advise us, the group contract holder will be responsible for the cost of any claims paid by us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 30 days.

    The group contract holder may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The "plan administrator" is the group contract holder, or a third party appointed by the group contract holder. We are not the ERISA plan administrator.

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

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

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

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

Grievances. Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

Filing a Grievance. You can contact Us by phone, in person or in writing to file a Grievance. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

Grievance Determination. Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That 45 calendar days of receipt of all or request for service.)	In writing, within are not in relation to a claim necessary information.

Grievance Appeals. If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone, in person, or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal. }

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of 2 business days of receipt of the necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for service.)	30 business days of receipt of all necessary information to make a determination

If You remain dissatisfied with Our Appeal determination or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

24. **Utilization Review.** We review proposed and rendered health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being rendered (prospective); when the service is being rendered (concurrent); or after the service is rendered (retrospective).

    We have developed Utilization Review policies to assist us in administering the Utilization Review program. These policies describe the process and procedures of Utilization Review activities. Reviews are conducted by registered nurses and our Medical Directors. All determinations that services are not Medically Necessary will be made by licensed physicians. We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not or were not Medically Necessary. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review at our office. For more information, you can contact us. Our failure to make a Utilization Review determination within the applicable time frames set forth below shall be deemed an adverse determination subject to an internal appeal.

    A. **Prospective Reviews.** All requests for prior authorization of care are reviewed for Medical Necessity (including the appropriateness of the proposed level of care and/or provider). The initial review is performed by a nurse. If the nurse determines that the proposed care is Medically Necessary, the nurse will authorize the care. If the nurse determines that the proposed care is not Medically Necessary or that further evaluation is needed, the nurse will refer the case to a licensed physician.

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

    With respect to prospective urgent claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 24 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

    B. **Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision. If we need additional information, we will request it within one business day. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within the earlier of one business day of our receipt of the information or, if we do not receive the information, within 15 calendar days of the end of the 45-day time period.

    For concurrent reviews that involve urgent matters, we will make a determination and provide notice to you (or your designee) and your provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified above for prospective urgent claims.

    If we have approved a course of treatment, we will not reduce or terminate the approved services unless we have given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

C. **Retrospective Reviews.** At our option, a nurse will review retrospectively the Medical Necessity of claims that are subject to Utilization Review. If the nurse determines that care you received was Medically Necessary, the nurse will authorize the benefits. If the nurse determines that Medical Necessity was lacking, the nurse will refer the case to a licensed physician.

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you and your provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to you and your provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

D. **Notice of Adverse Determination.** A notice of adverse determination (notice that a service is not Medically Necessary or is experimental/investigational) will include the reasons, including clinical rationale, for our determination, date of service, provider name, claim amount (if applicable), diagnosis code and treatment code, and corresponding meaning of these codes. The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal and an explanation of why the information is necessary. The notice will also refer to the plan provision on which the denial is based. We will send notices of determination to you (or your designee) and, as appropriate, to your health care provider.

E. **Internal Appeals of Adverse Determinations.** You, your designee and, in retrospective review cases, your health care provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing. You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

We will decide internal appeals related to prospective reviews within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and your health care provider if he or she requested the review) within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

We will decide internal appeals related to retrospective reviews within 60 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and your health care provider if he or she requested the review) within two business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

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

For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request.

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

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

G. **Your Right to an Immediate External Appeal.** If we fail to adhere to the utilization review requirements described above, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external appeal as described in Paragraph 29 below.

25. **External Appeal.**

A. **External Appeal in General.** You have the right to an "external appeal" of certain coverage determinations made by us. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by the State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal. "Requested service" or "requested services" refers to the service or services for which you are requesting coverage.

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

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

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

In general, you may not request an external appeal unless we have issued a "final adverse determination" of your request for coverage through the first level of the internal appeal process. You may ask us to agree to an external appeal even though you have not obtained a final adverse determination through the first level of the internal appeal process; however, we have no obligation to agree to your request. If we do agree, we will send you a letter stating that we have agreed to an external appeal even though you have not obtained a final adverse determination.

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

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

To request external appeal under this subparagraph, the final adverse determination must indicate that the requested service is not Medically Necessary. Subparagraph G below provides information on requesting an external appeal.

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

In order to request an external appeal under this subparagraph, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one that, according to the current diagnosis of your attending physician, has a high probability of causing your death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

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

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

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

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

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

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

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

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

(2) An entity that has been identified by the NIH as a qualified non-governmental research entity; or

(3) An Institutional Review Board of a facility that has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

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

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

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

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

(b) Affects less than 200,000 United States residents per year; and

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

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

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

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

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

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

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

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

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

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

(1) For services denied as not Medically Necessary, we will treat the service as Medically Necessary and provide coverage subject to all other conditions of this Certificate.

(2) For services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of this Certificate.

(3) For services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of this Certificate. We are not required to pay for drugs or devices that are the subject of the clinical trial.

(4) For services denied for treatment of a Rare Disease, we will provide coverage for the requested health service or procedure, subject to all other conditions of this Certificate, when a majority of the panel of external appeal reviewers determines, based on the certification described in Subparagraph F. (3) (a) above, and such other evidence as you, your designee or your attending physician may present, that the requested health service or procedure is likely to benefit you in the treatment of your Rare Disease and that such benefit outweighs the risks of such health service or procedure.

We will not provide coverage for any service that is not a covered service under this Certificate. In addition, this subparagraph does not alter any cost-sharing responsibilities as otherwise provided for in this Certificate.

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

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

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

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

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

SCHEDULE OF BENEFITS