At IAS Part 35 of the Supreme Court of the State of New York, County of New York, at the courthouse, 60 Centre Street, in the County, City and State of New York, on the 24 day of January, 2017.

PRESENT:

HON. CAROL R. EDMEAD, J.S.C.

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In the Matter of

the Liquidation of

HEALTH REPUBLIC INSURANCE OF NEW YORK, CORP.

----------X

Index No. 450500/2016

ORDER TO SHOW CAUSE

#004

Based upon the affirmation of Eliot Kirshnitz ("Kirshnitz Affirmation"), an attorney with the New York Liquidation Bureau, the organization that carries out the duties of Maria T. Vullo, Superintendent of Financial Services of the State of New York as liquidator ("Liquidator") of Health Republic Insurance of New York, Corp. ("Health Republic"), dated January 20, 2017, and upon all other papers previously submitted and all proceedings heretofore had herein;

NOW, on motion of the Liquidator, and after due deliberation having been had thereon;

LET all claimants and parties interested in the affairs of Health Republic show cause before this Court at IAS Part 35, Room 438, at the Courthouse located at 60 Centre Street, New York, New York 10007, on the 17th day of February, 2017 at 10:00 o'clock a.m. ("Return Date"), or as soon thereafter as counsel can be heard, why an order, substantially in the form of the proposed order attached as Exhibit D to the Kirshnitz Affirmation, should not be made confirming that, notwithstanding the existence of an anti-assignment provision in a Health Republic insurance policy, the Liquidator may, where appropriate, make an allowed payment

directly to a health care provider for the costs of covered services, whether the claim for payment was made by the policyholder, the health care provider, or both;

AND, sufficient cause having been alleged therefore, it is hereby

ORDERED, that the Liquidator shall give notice of this application by: (i) posting this Order to Show Cause and its supporting papers on the Health Republic Internet web page at http://www.healthrepublicny.org/ and the New York Liquidation Bureau Internet web page at http://www.nylb.org/ at least ten (10) days before the Return Date; and (ii) publishing the notice substantially in the form attached as Exhibit C to the Kirshnitz Affirmation in the *New York Post* and the *New York Daily News* within twenty (20) days following the date of issuance of this Order to Show Cause; and it is further

ORDERED, that a copy of answering papers, either in support of or opposition to the relief sought herein ("Answering Papers"), shall be served on the Liquidator at the following address:

Superintendent of Financial Services of the State of New York
as Liquidator of Health Republic Insurance of New York, Corp.
110 William Street, 15th Floor
New York, New York 10038
Attention: General Counsel

at least seven (7) days before the Return Date, and the original Answering Papers, together with an affidavit of service, shall be filed with the Court on or before the Return Date. No reply.

ENTER

J.S.C.

HON. CAROL R. EDMEAD
J.S.C.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK
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In the Matter of Index No. 450500/2016

the Liquidation of **AFFIRMATION**

HEALTH REPUBLIC INSURANCE OF
NEW YORK, CORP.
----------X

Eliot Kirshnitz, an attorney at law, duly admitted to practice law before the Courts of the State of New York, hereby affirms the following to be true under the penalties of perjury:

1. I am an attorney with the New York Liquidation Bureau ("Bureau"), the organization that carries out the duties of Maria T. Vullo, Superintendent of Financial Services of the State of New York as liquidator ("Liquidator") of Health Republic Insurance of New York, Corp. ("Health Republic"). I make this affirmation upon information and belief, the sources of which are files maintained by the Bureau and communications made to the affirmant by employees of the Bureau.

2. At the conference before the Court on October 11, 2016, counsel for a health care provider that has rendered services to former policyholders ("Members") of Health Republic, raised the possibility that claims could be filed against Health Republic's estate by a Member and by an out-of-network provider on account of the same services rendered to the Member by the provider. Counsel noted that the typical insurance policy contains a clause that is designed to prohibit or otherwise limit a policyholder's ability to assign to third parties benefits arising under the policy.

3. The Court requested that the Liquidator's counsel prepare a memorandum discussing whether, and under what circumstances, the Liquidator would be permitted to

recommend an allowance directly to the provider, rather than to the Member, notwithstanding the presence of an anti-assignment provision in the relevant Health Republic insurance policy.

4. In response to the Court's inquiry, attached hereto as Exhibit A is the memorandum requested by the Court.

5. In summary, the memorandum concludes:

a. Where a Member and a provider have made a claim arising from the provider's provision of covered services to the Member, the plain terms of Health Republic's policies would permit the Liquidator, in her discretion, to pay the provider directly for the services that are the subject of the claims without the need to alter, change or disregard any terms of the policies, including any anti-assignment provision in the policies. Health Republic's policies expressly afford Health Republic the discretion to either pay Members for the costs of covered services received from out-of-network providers, or pay providers directly on behalf of Members who received such services. The Liquidator thus may, in her discretion, pay out-of-network providers directly for the covered services they have rendered to Members without the need for the Court to effect any modification to the terms of the policies. See Ex. A at 2, 3-4.

b. Although it should not be necessary to reach this issue given the conclusion in (a) above, where a Member has assigned to a provider accrued benefits under a Health Republic insurance policy, such assignment is enforceable notwithstanding any provision in the policy prohibiting or otherwise limiting the Member's right to make such assignment. Public policy and precedent provide that an anti-assignment provision may not operate to restrict an insured's right to assign insurance policy benefits after the underlying loss giving rise to the claim for such benefits has occurred. Thus, where all losses have already occurred, Members may assign to out-of-network providers their rights to receive payments under their insurance

policies. In addition, any assignments previously executed by such Members may be enforced to allow providers to collect payment from Health Republic's estate on account of out-of-network services previously provided to such Members. See Ex. A at 2, 4-6.

6. Accordingly, there is no need for the Court to invalidate any anti-assignment provisions contained in Health Republic insurance policies to ensure that a distribution from Health Republic's estate can be made to the appropriate claimant. Under the plain terms of Health Republic's insurance policies, the Liquidator may, in her discretion and where appropriate, distribute benefits directly to the provider instead of to the Member.

7. If necessary, however, the Court may invalidate the anti-assignment provision in any applicable policy to the extent necessary to enforce a Member's assignment of his or her benefits to a provider, or to allow a Member to make such assignment in the first instance.

8. In accordance with the Court's instruction, the Liquidator has shared a copy of the memorandum with counsel for the health care provider that raised these issues, who has written a letter agreeing with the conclusions set forth in the memorandum. A copy of the letter is attached as Exhibit B.

9. The Liquidator requests that this Court issue the accompanying Order to Show Cause approving a return date ("Return Date") for a hearing on the Liquidator's application to be held before this Court at least twenty (20) days after the date of issuance of the Order to Show Cause.

10. Notice is sought through (i) posting the Order to Show Cause and its supporting papers on the Health Republic Internet web page at http://www.healthrepublicny.org/ and the New York Liquidation Bureau Internet web page at http://www.nylb.org/ at least ten (10) days before the Return Date; and (ii) publishing the notice substantially in the form attached as

Exhibit C hereto in the *New York Post* and the *New York Daily News* within twenty (20) days following the date of issuance of this Order to Show Cause.

11. No previous application for the relief sought herein has been made to this or any other court of judge thereof.

WHEREFORE, the Liquidator respectfully requests that this Court grant an order substantially in the form attached as Exhibit D hereto confirming that, notwithstanding the existence of an anti-assignment provision in a Health Republic insurance policy, the Liquidator may, where appropriate, make an allowed payment directly to a health care provider for the costs of covered services, whether the claim for payment was made by the policyholder, the health care provider, or both.

Dated: New York, New York
January 20, 2017

JOHN PEARSON KELLY,
Attorney for Maria T. Vullo, Superintendent of Financial Services of the State of New York as Liquidator of Health Republic Insurance of New York, Corp.

By: _____

Eliot Kirshnitz
New York Liquidation Bureau
110 William Street, 15th Floor
New York, New York 10038

Exhibit A

Weil

Memorandum

January 20, 2017

Re The Court's Ability to Alter Contractual Provisions to Resolve Duplicative Claims Filed against the Liquidation Estate of Health Republic Insurance of New York, Corp.

I.

BACKGROUND AND QUESTIONS PRESENTED

At the conference before the Court on October 11, 2016, counsel for a health care provider that has rendered services to former policyholders (each, a "**Member**") of Health Republic Insurance of New York Corp. ("**HRINY**"), raised the possibility that claims could be filed against HRINY's estate by a Member and by an out-of-network provider on account of the same services rendered to the Member by the provider, thereby creating duplicative claims against the estate. Counsel for the health care provider pointed out that the typical insurance policy contains a clause that is designed to prohibit or otherwise limit a policyholder's ability to assign to third parties benefits arising under the policy. The Court thus sought to ensure that, under appropriate circumstances, any distribution from HRINY's estate on account of services giving rise to duplicative claims can flow to the provider who has provided services to the Member, notwithstanding an anti-assignment clause in an applicable HRINY-issued insurance policy. In that regard, the Court requested that Weil, Gotshal & Manges LLP, counsel for Maria T. Vullo, in her capacity as Court-appointed Liquidator of HRINY (the "**Liquidator**"), prepare a memorandum discussing whether, under the circumstances described above, the Court could invalidate an applicable anti-assignment provision to the extent necessary to allow the Liquidator to distribute policy proceeds directly to the provider, rather than to the Member.

In response to the Court's inquiry, this memorandum addresses the following questions:

(1) Notwithstanding an anti-assignment provision in an applicable HRINY-issued insurance policy, may the Liquidator pay an out-of-network provider directly for the cost of services provided to a Member?

(2) Even if, arguendo, the Liquidator did not have the ability to pay an out-of-network provider directly for the cost of services provided to a Member under the plain terms of an applicable HRINY-issued insurance policy, would the Court have the ability to disregard or invalidate an anti-assignment provision in such policy to authorize or enforce an assignment of policy benefits by the Member to the provider?

II.

SHORT ANSWERS

A. The Liquidator May Pay Providers Directly

Notwithstanding the existence of an anti-assignment provision in an applicable HRINY-issued insurance policy, under the plain terms of HRINY's policies, the Liquidator may pay the provider directly for the services that are the subject of the duplicative claims. HRINY's policies expressly afford HRINY the discretion to either pay Members for the costs of covered services received from out-of-network providers, or pay providers directly on behalf of Members who received such services. The Liquidator thus may, in her discretion, pay non-participating providers directly for the covered services they have rendered to Members. The result of this discretion is that it resolves any duplicative claims filed against HRINY's estate by a Member and an out-of-network provider, where such claims arise from the same services rendered to the Member by the provider, and ensure that any distribution from HRINY's estate on account of such services is made to the proper claimant (*i.e.*, the claimant who is actually "out-of-the-money" with respect to the services giving rise to the duplicative claims). The ability of the Liquidator to pay providers directly under the terms of HRINY's policies makes it unnecessary for the Court to invalidate or disregard anti-assignment provisions contained in the policies.

B. The Court May Invalidate the Anti-Assignment Provisions in HRINY's Insurance Policies

Even if, arguendo, the Liquidator did not have the ability to pay an out-of-network provider directly for the cost of services provided to a Member under the plain terms of an applicable HRINY-issued insurance policy, the Court could invalidate or disregard an anti-assignment provision in such policy as being contrary to public policy in the circumstances where an insured has assigned insurance policy benefits to a provider and the underlying loss giving rise to the claim for such benefits has occurred. In accordance with New York public policy and a long-standing body of case law, in the context of HRINY's liquidation proceeding, and under the circumstances herein described, a Member's assignment to a provider of his or her accrued benefits under an HRINY-issued insurance policy is enforceable notwithstanding any provision in the policy prohibiting or otherwise limiting the Member's right to make such assignment. Public policy and precedent provide that an anti-assignment provision may not operate to restrict an insured's right to assign insurance policy benefits after the underlying loss giving rise to the claim for such benefits has occurred. All of the benefits under HRINY's insurance policies already have accrued, and, therefore, Members may assign to out-of-network providers their rights to receive payments under their insurance policies. In addition, any assignments previously executed by such Members may be enforced to allow providers to collect payment from HRINY's estate on account of out-of-network services previously provided to such Members.

III.

DISCUSSION

A. The HRINY Policies Authorize Payment to Either the Provider or the Member.

Prior to winding down its operations in November 2015, HRINY issued individual and small group health insurance policies to New Yorkers (the "**Policies**" and, each, a "**Policy**"). Attached hereto, respectively, as **Exhibit 1** and **Exhibit 2**, are a sample individual Policy and a sample group Policy issued by HRINY. The Policies cover health care and pharmaceutical services provided to HRINY's Members. All of the benefits under the Policies already have accrued. Generally, the Policies provide that insurance proceeds (the "**Benefits**") will be distributed either to the Member or to health care providers who provide services giving rise to claims under the Policies.

> **Who Receives Payment under This Contract.** Payments under this Contract for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, **We reserve the right to pay either You or the Provider regardless of whether an assignment has been made**.

Individual Policy, § 25.33 (emphasis added).

> **Who Receives Payment under This Certificate.** Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, **We reserve the right to pay either You or the Provider regardless of whether an assignment has been made**.

Group Policy, § 13.29 (emphasis added).

Because HRINY had the discretion to pay either a Member or an out-of-network provider for the Member's receipt of services from such provider, there may be instances in which a Member and a provider each file a claim against HRINY's estate arising from the same services. In that instance, the Member would be seeking a distribution from HRINY's estate to satisfy a debt the Member owes to the provider, and the provider would be seeking a distribution from HRINY's estate to cover its costs of having provided services to the Member. Under a scenario where the provider has provided services without payment, the proper payee would be the provider, as paying the Member could result in a windfall to the Member at the provider's expense (for example, should the Member then fail to pay such amount over to the provider). This would remain true even if HRINY paid the Member for the cost of services provided by the out-of-network provider, and the Member owed such amounts to the provider.

Because the Policies afford HRINY the discretion to pay either a Member or a provider, and the Liquidator, acting on behalf of HRINY, has the same rights under the Policies, the Liquidator may resolve duplicative claims (as described in this memorandum) by distributing the Policy Benefits

directly to the appropriate claimant. Under the circumstances described above, the appropriate claimant would be the provider. Neither the Policies themselves nor Benefits under those Policies need to be assigned by the Member in order for payment to be made to the provider.

B. If Necessary, a Court May Invalidate an Anti-Assignment Provision as Contrary to Public Policy under Circumstances Relevant in HRINY's Liquidation Proceeding.

Under New York Law, it is well-established that where an underlying loss giving rise to a claim for benefits under an insurance policy already has occurred, an assignment of such benefits is allowed even if the policy contains an "absolute bar"[1] on assignment. *See, e.g., Kittner v. E. Mut. Ins. Co.*, 80 A.D.3d 843, 846, 915 N.Y.S.2d 666, 669 (2011) (noting that, under New York law, an anti-assignment provision "applies only to assignments before loss"); *Courtney v. N.Y. City Ins. Co.*, 28 Barb. 116 (N.Y. Gen. Term. 1858) (calling into question the enforceability of a provision, the purpose of which would be to bar assignment of benefits *after* a claim accrued); *Carroll v. Charter Oak Ins. Co.*, 38 Barb. 402 (N.Y. Gen. Term. 1862) (same); *see Globecon Grp., LLC v. Hartford Fire Ins. Co.*, 434 F.3d 165, 170 (2d Cir. 2006) ("As a general matter, New York follows the majority rule that such [an anti-assignment] provision is valid with respect to transfers that were made prior to, but not after, the insured-against loss has occurred.").[2]

By contrast, courts generally will uphold anti-assignment provisions with regard to the assignment of policy benefits prior to the occurrence of a claim-triggering loss under the applicable policy. *See, e.g., Travelers Indem. Co. v. Israel*, 354 F.2d 488, 490 (2d Cir. 1965) ("Although assignment of the policy prior to loss was ineffective without the consent of the insurer, no such approval was necessary for an assignment of the right to the proceeds after the loss.").

Courts take a different approach to the enforcement of anti-assignment provisions prior to the occurrence of a claim-triggering loss, because courts recognize the protection afforded to insurers by restrictions on assignment at such time. An anti-assignment provision is only valuable to an insurer for the purpose of maintaining the insurer's return on the individualized process of performing risk assessment on the insurer's members. To transfer the protections of the policy before a loss has occurred would shift the risk without allowing the insurer to make any necessary financial adjustments. *See Globecon*, 434 F.3d at 171 ("The suggestion is that the accrual of an insurance claim extinguishes the insurer's interest in the risk profile of the insured, thereby converting the claim into, in effect, a

[1] An absolute bar would be a blanket statement prohibiting all assignment, versus a bar on assignment without the consent of an insurer, discussed in section II(c), *infra*.

[2] New York has one narrow exception to its permission of post-loss assignability, which functions more as a clarification than an exception, and is not relevant to the questions addressed in this memorandum. Where business interruption losses occur, for example, as caused by a fire, and the claim for insurance proceeds is transferred to a third party, only those losses that have been assessed and determined prior to the transfer will be assigned to the third party. *Bronx Entm't LLC v. St. Paul's Mercury Ins. Co.*, 265 F.Supp.2d 359, 363 (S.D.N.Y.2003); *Holt v. Fidelity Phoenix Fire Ins. Co.*, 76 N.Y.S.2d 398 (1948) (where, after a fire forced a theater to close, assigning the rights to recoupment to a new theater owner was outside the force of the contract because the contract contemplated reimbursement by the business that suffered the loss's probable experience thereafter).

chose in action."). Put differently, anti-assignment provisions are necessary and should be enforced to prevent an insured, prior to a loss, from transferring the protections it receives under an insurance policy to a third party who is not named as an insured under such policy without first allowing the insurer the opportunity to assess the transferee's risk profile. Where an insured transfers policy benefits prior to a loss, the risk profile of the insured could change and increase the insurer's exposure without providing the insurer additional consideration in exchange. These policy considerations are inapplicable in the case of an insured assigning its benefits under an insurance policy to a third party following a claim-triggering loss, as risk profile is no longer of any relevance as to Benefits already accrued.

HRINY's Policies contain the following provisions restricting Members' rights to assign their Benefits to third parties:

> **Assignment.** You cannot assign any monies due under this Contract to any person, corporation or other organization unless it is an assignment to Your Physician for a surprise bill for Covered Services provided on and after April 1, 2015. See the How Your Coverage Works section of this Contract for more information about surprise bills. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Contract or your right to collect money from us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

Individual Policy, § 25.2.

> **Assignment.** You cannot assign any monies due under this Certificate to any person, corporation. 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. However, You may request Us to make payment for services directly to Your Provider instead of You.

Group Policy, § 13.2

For the reasons outlined above, in the context of HRINY's liquidation proceeding, these provisions should not invalidate or prevent assignments by Members of their Benefits for claims resulting from losses that already have occurred. All of the Benefits under the Policies already have accrued. That is to say, any Member who is entitled to Benefits under one of HRINY's Policies already has incurred a claim-triggering loss thereunder. Because all losses already have occurred, Members are entitled to assign their rights to payment under the Policies to providers from whom they have received services, and any assignments that already have been executed should be enforced to allow the provider to collect payment from HRINY's estate. *See Travelers Indem.*, 354 F.2d at 490. Accordingly, even if the Liquidator did not exercise her discretion under the Policies to pay an out-of-network provider directly for services rendered to a Member, duplicative claims against HRINY's estate that arise from a

transaction between the provider and the Member could be resolved by distributing benefits from HRINY's estate in accordance with an assignment of benefits executed by the Member in favor of the provider. Thus, the Court may, if necessary, enforce an assignment notwithstanding an anti-assignment provision under the circumstances herein described.

IV.

CONCLUSION

The Court should not need to invalidate the anti-assignment provisions contained in HRINY's Policies to ensure that, in appropriate circumstances, a distribution from HRINY's estate on account of services giving rise to duplicative claims can be made to the appropriate claimant. Under the plain terms of the Policies, the Liquidator may distribute the Member's Benefits directly to the provider instead of to the Member. In the event that the Liquidator does not exercise her right to pay the provider in this scenario, the Court may invalidate the anti-assignment provision in the applicable Policy to the extent necessary to enforce a Member's assignment of his or her Benefits to a provider, or to allow a Member to make such assignment in the first instance. Any Policy provision that prohibits or otherwise limits a Member's right to make such assignment should be unenforceable given that all Benefits under HRINY's Policies already have accrued. In light of the foregoing, there are ample mechanisms in place to ensure that any duplicative claims filed against HRINY's estate under the circumstances herein described not only will be resolved, but also will be settled in such a way that ensures that only one claimant—and the appropriate claimant—receives a distribution from HRINY's estate on account of the services giving rise to such claims.

Exhibit 1

(Sample HRINY Individual Policy)

HEALTH REPUBLIC
INSURANCE

This is Your

EXCLUSIVE PROVIDER ORGANIZATION CONTRACT

Issued by

Health Republic Insurance of New York
[30 Broad Street 34th Floor
New York, New York 10004]

This is Your individual direct payment Contract for exclusive provider organization coverage issued by Health Republic Insurance of New York. This Contract, together with the attached Schedule of Benefits, applications, and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

You have the right to return this Contract. Examine it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Contract. We will refund any Premium paid, including any Contract fees or other charges.

Renewability. Refer to the Termination of Coverage section of this Contract for the renewal provisions.

In-Network Benefits. This Contract only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in Our Network, [MagnaCare Extra Network]. Except for care for an Emergency Condition described in Emergency Services and Urgent Care section of this Contract, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

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

This Contract is governed by the laws of New York State.

[Signed By: Debra Friedman
Debra Friedman
Chief Executive Officer]

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SECTION I. DEFINITIONS

Defined terms will appear capitalized throughout the Contract.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Contract for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Children: The Subscriber's Children, including any natural, adopted, or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the "Who is Covered" section of this Contract.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider.

Contract: This Contract issued by Health Republic Insurance of New York, including the Schedule of Benefits and any attached riders.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Coinsurance, Copayments, and/or Deductibles.

Cover, Covered, or Covered Services: The Medically Necessary services paid for or arranged for You by Us under the terms and conditions of this Contract.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Coinsurance or Copayments are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Durable Medical Equipment (DME): Durable Medical Equipment is equipment which is:
- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the Department of Financial Services to perform external appeals in accordance with New York law.

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; a comprehensive care center for eating disorders pursuant to article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility). If You receive treatment for chemical dependence or abuse outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Habilitation Services: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy, and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized, who charges and bills patients for Covered Services. The Health Care Professional's services must be

rendered within the lawful scope of practice for that type of Provider in order to be covered under this Contract.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment, and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- if located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97 (42 U.S.C. § 1395x(k));
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

Medically Necessary: See the How Your Coverage Works section of this Contract for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a Covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

New York State of Health ("NYSOH"): The New York State of Health, the Official Health Plan Marketplace.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider. The services of Non-Participating Providers are Covered only for Emergency Services or when authorized by Us.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at [http://healthrepublicny.org/for-members/find-a-provider/] or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: A calendar year ending on December 31 of each year.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, treatment plan, device, or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Contract.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product, or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or refill, and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Primary Care Physician: A Participating Physician who typically is an internal medicine, family practice, or pediatric doctor and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, licensed Health Care Professional or Facility licensed, registered, certified, or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a Participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider. A Referral is not required but needed in order for You to pay the lower Cost-Sharing for certain services listed in the Schedule of Benefits section of this Certificate.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The Section of this Contract that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, Referral requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of the following counties: Albany, Allegany, Bronx, Cattaraugus, Cayuga, Chautauqua, Columbia, Delaware, Dutchess, Erie, Essex, Genesee, Greene, Hamilton, Kings, Livingston, Monroe, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange,

Orleans, Oswego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Seneca, Suffolk, Sullivan, Ulster, Warren, Washington, Wayne, Westchester, Wyoming and Yates.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse and a domestic partner.

Subscriber: The person to whom this Contract is issued.

UCR (**Usual, Customary, and Reasonable):** The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Participating Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: Health Republic Insurance of New York and anyone to whom We legally delegate performance, on Our behalf, under the Contract.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II. HOW YOUR COVERAGE WORKS

2.1 Your Coverage under this Contract
You have purchased a health insurance Contract from Us. We will provide the benefits described in this Contract to You and Your Covered Dependents. You should keep this Contract with Your other important papers so that it is available for Your future reference.

2.2 Covered Services
You will receive Covered Services under the terms and conditions of this Contract only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Contract; and
- Received while Your Contract is in force.

When You are outside Our Service Area, coverage is limited to Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

2.3 Participating Providers
To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request.
- Call Member Services.
- Visit our website at [http://healthrepublicny.org/for-members/find-a-provider/].

2.4 The Role of Primary Care Physicians
This Contract does not have a gatekeeper, usually known as a Primary Care Physician (PCP). You do not need a written Referral from a PCP before receiving Specialist care from a Participating Provider. For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Contract.

2.5 Services Subject To Preauthorization
Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network services listed in the Schedule of Benefits section of this Contract.

2.6 Preauthorization/Notification Procedure
If You seek coverage for services that require Preauthorization or notification, You must call Us at the number indicated on Your ID card.

You must contact Us to request Preauthorization as follows:

- At least two weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in a free standing Ambulatory Surgical Center.
- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

2.7 Failure to Seek Preauthorization or Provide Notification
If You fail to seek Our Preauthorization or provide notification for benefits subject to this Section, We will pay an amount $500 less than We would otherwise have paid for the care, or We will pay only 50% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining charges. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization or provide notification. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

2.8 Medical Management
The benefits available to You under this Contract are subject to pre-service, concurrent, and retrospective reviews to determine when services should be covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

2.9 Medical Necessity
We Cover benefits described in this Contract as long as the health care service, procedure, treatment, test, device, Prescription 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 Cover it.

We may base Our decision on a review of: Your medical records; Our medical policies and clinical guidelines; medical opinions of a professional society, peer review committee or other groups of Physicians; reports in peer-reviewed medical literature; reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data; professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment; the opinion of Health Care Professionals in the generally-recognized health specialty involved; and the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:
- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;

- They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

  See the Utilization Review and External Appeals section of this Contract for Your right to an internal appeal and external appeal of Our determination that a service is not Medically Necessary.

2.11 Protection from Surprise Bills

A surprise bill is a bill You receive [for Covered Services provided on and after April 1, 2015] in the following circumstances:

1. For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
   i. A participating Physician is unavailable at the time the health care services are performed;
   ii. A non-participating Physician performs services without Your knowledge; or
   iii. Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Physician is available and You elected to receive services from a non-participating Physician.

2. You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the Referral is to a Non-Participating Provider and it may result in costs not covered by Us.

You will be held harmless for any non-participating Physician charges for the surprise bill that exceed Your Copayment, Deductible or Coinsurance if You assign benefits to the non-participating Physician in writing. In such cases, the non-participating Physician may only bill You for Your Copayment, Deductible or Coinsurance.

2.11 Important Telephone Numbers and Addresses

CLAIMS
*Submit claim forms to this address.
Health Republic Insurance of New York
[P.O. Box 6329
Syracuse, NY 13217-6329]

COMPLAINTS, GRIEVANCES, AND UTILIZATION REVIEW APPEALS
Health Republic Insurance of New York
[2425 James Street
Syracuse, NY 13206
Phone: 888.990.5702
Fax: 315-433-5445]

MEMBER SERVICES
[* Member Services Representatives are available Monday – Friday 8:30 a.m. – 5:30 p.m. EST
Phone: 888.990.5702
Fax: 315-432-9442]

PREAUTHORIZATION
[Monday – Friday 8:00 a.m. – 6:00 p.m. EST
Phone: 888.990.5702
Fax: 315-433-5442]

OUR WEBSITE
[http://healthrepublicny.org]

SECTION III. ACCESS TO CARE AND TRANSITIONAL CARE

3.1 Referral to a Non-Participating Provider

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve a Referral to an appropriate Non-Participating Provider. Your Participating Provider or You must request prior approval of the Referral to a specific Non-Participating Provider. Approvals of Referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, Your Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing. In the event a Referral is not approved, any services rendered by a Non-Participating Provider will not be Covered.

3.2 When Your Provider Leaves the Network

If You are in an ongoing course of treatment when Your Provider leaves Our Network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered services for up to ninety (90) days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-Network Cost-Sharing. Please note that if the Provider was terminated by Us 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.

3.3 New Members In a Course of Treatment

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Contract becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to sixty (60) days from the effective date of Your coverage under this Contract. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Contract becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered services for up to sixty (60) days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the

Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

SECTION IV. COST-SHARING EXPENSES AND ALLOWED AMOUNT

4.1 Deductible

[Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Contract for Covered in-network Services during each Plan Year before We provide coverage. If You have other than Individual coverage, the individual Deductible applies to each person covered under this Contract. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for all persons covered under this Contract collectively total the family Deductible amount in the Schedule of Benefits section of this Contract in a Plan Year, no further Deductible will be required for any person covered under this Contract for that Plan Year.

The Deductible runs from January 1 to December 31 of each calendar year.]
[There is no Deductible for Covered Services under the Contract during each Plan Year.]

4.2 Copayments

Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Contract for Covered in-network Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

4.3 Coinsurance

Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network benefit as shown in the Schedule of Benefits section of this Contract.

4.4 Out-of-Pocket Limit

When You have met Your Out-of-Pocket Limit in payment of Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits section XIII of this Contract, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. Once a person within a family meets the individual Out-of-Pocket Limit, We will provide coverage for 100% of the Allowed Amount for the rest of the Plan Year for that person. If other than Individual coverage applies, when members of the same family covered under this Contract have collectively met the family Out-of-Pocket Limit in payment of Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year.

Cost-Sharing for out-of-network services, except for Emergency Services and out-of-network dialysis, does not apply toward Your Out-of-Pocket Limit. The Pre-Authorization penalty described in the How Your Coverage Works section of this Contract does not apply toward your Out-of-Pocket Limit.

4.5 Allowed Amount

"Allowed Amount" means the maximum amount we will pay to a Provider for the services or supplies covered under this Contract, before any applicable Deductible, Copayment, and Coinsurance amounts are subtracted. We determine our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider.

See Section IV of the Contract for the Allowed Amount for an Emergency Condition.

SECTION V. WHO IS COVERED

5.1 Who is Covered Under this Contract

You, the Subscriber to whom this Contract is issued, are covered under this Contract. You must live or reside in Our Service Area to be covered under this Contract. If You are enrolled in Medicare, You are not eligible to purchase this Contract. Members of Your family may also be covered depending on the type of coverage You selected.

5.2 Types of Coverage

We offer the following types of coverage:

- Individual – If You selected Individual coverage, then You are covered.
- Individual and Spouse – If You selected Individual and Spouse coverage, then You and Your Spouse are covered.
- Parent and Child/Children – If You selected Parent and Child/Children coverage, then You and Your Child or Children, as described below, are covered.
- Family – If You selected Family coverage, then You, Your Spouse, and Your Children, as described below, are Covered.

5.3 Children Covered Under This Contract

If You selected Parent and Child/Children or Family coverage, Children covered under this Contract include Your natural Children, legally adopted Children, step-Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status, or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate, and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this Section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or Covered Subscriber and all other prospective or Covered Members in relation to eligibility for coverage under this Contract at any time.

5.4 Open Enrollment

[For Plan Years beginning on or after January 1, 2015, You can enroll under this Contract during an open enrollment period that runs from November 15, 2014 through February 15, 2015. If NYSOH receives Your selection on or before December 15, 2014, Your coverage will begin on January 1, 2015, as long as the applicable premium payment is received by then. If the NYSOH receives Your selection between the dates of December 16, 2014 through January 15, 2015, Your coverage will begin on February 1, 2015 as long as the applicable premium payment is received by then. If the NYSOH receives Your selection between the dates of January 16, 2015 through February 15, 2015, Your coverage will begin on March 1, 2015 as long as the applicable premium payment is received by then.]

If You do not enroll during open enrollment, or during a special enrollment period as described below, You must wait until the next annual open enrollment period to enroll.

5.5 Special Enrollment Periods

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child can enroll for coverage within 60 days prior to or after the occurrence of one of the following events:

1. You, Your Spouse or Child involuntarily loses minimum essential coverage, including COBRA or state continuation coverage;
2. You, Your Spouse or Child are determined newly eligible for advance payments of the premium tax credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, including as a result of Your employer discontinuing or changing available coverage within the next 60 days, provided that You are allowed to terminate existing coverage; or
3. You, Your Spouse or Child loses eligibility for Medicaid coverage, including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy, but not including other Medicaid programs that do not provide coverage for primary and specialty care.

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child can enroll for coverage within 60 days after the occurrence of one of the following events:

1. You, Your Spouse or Child's enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the NYSOH as evaluated and determined by the NYSOH;
2. You, Your Spouse or Child adequately demonstrate to the NYSOH that another qualified health plan in which You were enrolled substantially violated a material provision of its contract;
3. You, Your Spouse or Child move and become eligible for new qualified health plans;
4. You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption or foster care;
5. If You are an Indian, as defined in 25 U.S.C. 450b(d), You may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
6. You, Your Spouse or Child demonstrate to the NYSOH that You meet other exceptional circumstances as the NYSOH may provide;
7. You, Your Spouse or Child were not previously a citizen, national, or lawfully present individual and You gain such status;
8. You, Your Spouse or Child are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions; or
9. You demonstrate to the NYSOH that You or Your Spouse or Child were not enrolled in qualified health plan coverage; were not enrolled in the qualified health plan selected by You; or are eligible for but are not receiving advance payments of the premium tax credit of cost-sharing reductions as a result of misconduct on the part of a non-NYSOH entity providing enrollment assistance or conducting enrollment activities.

The NYSOH must receive notice and We must receive any premium payment within 60 days of one of these events.

If You, Your Spouse or Child enroll because You are losing minimum essential coverage within the next 60 days, or You are determined newly eligible for advance payments of the premium tax credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, Your coverage will begin on the first day of the month following Your loss of coverage.

If You enroll because You got married, Your coverage will begin on the first day of the month following Your election of coverage.

If You have a newborn or adopted newborn Child and the NYSOH receives notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which the NYSOH receives notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have Individual or Individual and Spouse coverage You must also notify the NYSOH of Your desire to switch to parent and child/children or family coverage and pay any additional premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which the NYSOH receives notice and We receive the premium payment.

Advance payments of any premium tax credit and cost-sharing reductions are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.

In all other cases, the effective date of Your coverage will depend on when the NYSOH receives Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable premium payment is received by then. If Your selection is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month, as long as Your applicable premium payment is received by then.

5.6 Domestic Partner Coverage

This Contract covers domestic partners of Subscribers as Spouses. If You selected Family coverage, "Children" covered under this Contract also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
    a. The affidavit must be notarized and must contain the following:
        - The partners are both eighteen years of age or older and are mentally competent to consent to contract.
        - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York
        - The partners have been living together on a continuous basis prior to the date of the application;
        - Neither individual has been registered as a member of another domestic partnership within the last six months; and
    b. Proof of cohabitation (e.g., a driver's license, tax return, or other sufficient proof); and
    c. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
        - A joint bank account

- A joint credit card or charge card
- Joint obligation on a loan
- Status as an authorized signatory on the partner's bank account, credit card, or charge card
- Joint ownership of holdings or investments
- Joint ownership of residence
- Joint ownership of real estate other than residence
- Listing of both partners as tenants on the lease of the shared residence
- Shared rental payments of residence (need not be shared 50/50)
- Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
- A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
- Shared household budget for purposes of receiving government benefits
- Status of one as representative payee for the other's government benefits
- Joint ownership of major items of personal property (e.g., appliances, furniture)
- Joint ownership of a motor vehicle
- Joint responsibility for child care (e.g., school documents, guardianship)
- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)
- Execution of wills naming each other as executor and/or beneficiary
- Designation as beneficiary under the other's life insurance Contract
- Designation as beneficiary under the other's retirement benefits account
- Mutual grant of durable power of attorney
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
- Affidavit by creditor or other individual able to testify to partners' financial interdependence
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI. PREVENTIVE CARE

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles, or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at [888-990-5702] or visit Our website at [http://healthrepublicny.org] for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

6.1 Well-Baby and Well-Child Care

We Cover well-baby and well-child care which consist of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one well-child visit per calendar year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles, or Coinsurance when provided by a Participating Provider.

6. 2 Adult Annual Physical Examinations

We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the Covered preventive services is available on Our website at [http://healthrepublicny.org] , or will be mailed to You upon request.

You are eligible for a physical examination once every Plan Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

6. 3 Adult Immunizations

We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

6. 4 Well-Woman Examinations
We Cover well-woman examinations which consist of a routine gynecological examination, breast examination, and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive services is available on Our website at [http://healthrepublicny.org], or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

6. 5 Mammograms
We Cover mammograms for the screening of breast cancer as follows:

- one baseline screening mammogram for women age 35 through 39; and
- one baseline screening mammogram annually for women age 40 and over.

If a woman of any age has a history of breast cancer, or her first degree relative has a history of breast cancer, We Cover mammograms as recommended by her Provider. However, in no event will more than one preventive screening, per Plan Year, be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than the above schedule, and when provided by a Participating Provider.

Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are Covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to Copayments, Deductibles, or Coinsurance.

6. 6 Family Planning & Reproductive Health Services
We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of the Contract, counseling on use of contraceptives, related topics and sterilization procedures for women. Such services are not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

We also Cover vasectomies.

We do not Cover services related to the reversal of elective sterilizations.

6. 7 Bone Mineral Density Measurements or Testing
We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of the Contract. Bone mineral density measurements or tests, drugs, or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
- On a prescribed drug regimen posing a significant risk of osteoporosis; or

- With lifestyle factors to 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.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

6. 8 Screening for Prostate Cancer

We Cover 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. We also Cover 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.

This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided by a Participating Provider.

SECTION VII. AMBULANCE AND PRE-HOSPITAL EMERGENCY MEDICAL SERVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

7.1 Emergency Ambulance Transportation

We Cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition, when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the N.Y. Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Coinsurance, or Deductible.

We also Cover emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed.

We Cover Pre-Hospital Emergency Medical Services and emergency ambulance transportation worldwide.

7.2 Non-Emergency Ambulance Transportation

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a Non-Participating Hospital to a Participating Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care Facility.
- From an Acute Facility to a sub-Acute setting.

7.3 Limitations/Terms of Coverage

We do not Cover travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.

We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.

Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land

ambulance is not appropriate; **and** Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; **and** one of the following is met:

- The point of pick-up is inaccessible by land vehicle; or
- Great distances or other obstacles (for example, heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

SECTION VIII. EMERGENCY SERVICES AND URGENT CARE

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

8.1 Emergency Services

We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an **Emergency Condition** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain;
- Severe or multiple injuries;
- Severe shortness of breath;
- Sudden change in mental status (e.g., disorientation);
- Severe bleeding;
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis;
- Poisonings; or
- Convulsions.

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs.

8.1.1 Hospital Emergency Department Visits

In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**. If You are uncertain whether this is the most appropriate place to receive care You can call Us before You seek treatment. Our Medical Management Coordinators are available 24 hours a day, 7 days a week. Your Coordinator will direct You to the emergency department of a Hospital or other appropriate Facility.

We do not Cover follow-up care or routine care provided in a Hospital emergency department. You should contact Us to make sure You receive the appropriate follow-up care.

8.1.2 Emergency Hospital Admissions

In the event You are **admitted** to the Hospital: You or someone on Your behalf must notify Us at the telephone number listed in this Contract and on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

We Cover inpatient Hospital services at a Non-Participating Hospital at the In-Network Cost-Sharing for as long as Your medical condition prevents Your transfer to a Participating Hospital, unless We authorize continued treatment at the Non-Participating Hospital. If Your medical condition permits Your transfer to a Participating Hospital, We will notify You and arrange the transfer. Any inpatient Hospital services received from a Non-Participating Hospital after we have notified You and arranged for a transfer to a Participating Hospital will not be Covered.

8.1.3 Payments Relating to Emergency Services Rendered

The amount We pay a Non-Participating Provider for Emergency Services will be the greater of: (1) the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); (2) 100% of the Allowed Amount for Services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or (3) the amount that would be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

You are responsible for any Deductible, Coinsurance, or Copayment. You will be held harmless for any Non-Participating Provider charges that exceed Your Deductible, Coinsurance or Copayment.

8.2 Urgent Care

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. **Urgent Care is Covered in Our Service Area**.

A. In-Network

We Cover Urgent Care from a Participating Physician or a Participating Urgent Care Center.

B. Out-of-Network

We do not cover Urgent Care from Non-Participating Urgent Care Centers or Physicians in Our Service Area.

If Urgent Care results in an Emergency admission, please follow the instructions for Emergency Hospital admissions described above.

SECTION IX. OUTPATIENT AND PROFESSIONAL SERVICES
(For other than Mental Health and Substance Use)

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

9.1 Advanced Imaging Services
We Cover PET scans, MRI, nuclear medicine, and CAT scans.

9.2 Allergy Testing and Treatment
We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

9.3 Ambulatory Surgery Center
We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the Center the day the surgery is performed.

9.4 Chemotherapy
We Cover Chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Contract.

9.5 Chiropractic Services
We Cover chiropractic care when performed by a Doctor of Chiropractic ("Chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this Contract.

9.6 Clinical Trials
We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

1. Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
2. Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Contract.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Contract for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:

1. A federally funded or approved trial;
2. Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
3. A drug trial that is exempt from having to make an investigational new drug application.

9.7 Dialysis
We Cover dialysis treatments of an Acute or chronic kidney ailment.

We also Cover dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than ten dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

9.8 Habilitation Services
We Cover Habilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition, per lifetime. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

9.9 Home Health Care
We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes (i) part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational, or speech therapy provided by the Home Health Agency, and (iv) Medical Supplies, Prescription Drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to 40 visits per Plan year. Each visit by a member of the Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is one visit. Please note: Any Rehabilitation or Habilitation services received under this benefit will not reduce the amount of services available under the Rehabilitation and Habilitation Services benefits.

9.10 Infertility Treatment
We Cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease, or dysfunction. Such Coverage is available as follows:

- Basic Infertility Services. Basic Infertility Services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, endometrial biopsy, pelvic ultra sound, hysterosalpingogram, sono-hystogram, testis biopsy, blood tests, and medically appropriate treatment of ovulatory dysfunction. Additional tests may be Covered if the tests are determined to be Medically Necessary.
- Comprehensive Infertility Services . If the Basic Services do not result in increased fertility, We Cover Comprehensive Infertility Services. Comprehensive Infertility services include: ovulation induction and monitoring; pelvic ultra sound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.
- Exclusions and Limitations. We do not Cover:
    a. In vitro, GIFT, and ZIFT procedures.
    b. Cost for an ovum donor or donor sperm.
    c. Sperm storage costs.
    d. Cryopreservation and storage of embryos.
    e. Ovulation predictor kits.
    f. Reversal of tubal ligations. Reversal of vasectomies.
    g. All costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers).
    h. Sex change procedures.
    i. Cloning.
    j. Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.

All services 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.

9.11 Infusion Therapy
We Cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected into the muscles are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count towards Your home health care visit limit.

9.13 Interruption of Pregnancy
We Cover therapeutic abortions. We also Cover non-therapeutic abortions in cases of rape, incest, or fetal malformation. We Cover elective abortions for one procedure per Member, per Plan Year.

9.13 Laboratory Procedures, Diagnostic Testing and Radiology Services
We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

9.14 Maternity and Newborn Care
We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one visit for genetic testing), postnatal care, delivery,

and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of the Contract for coverage of inpatient maternity care.

We Cover the cost of renting one breast pump per pregnancy for the duration of breast feeding.

9.15 Medications for Use in the Office: We Cover medications and injectables (excluding self-injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Contract.

9.16 Office Visits
We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

9.17 Outpatient Hospital Services
We Cover Hospital services and supplies as described in the Inpatient Hospital section of this Contract that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy, and cardiac rehabilitation. **Please remember**, unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests.

9.18 Preadmission Testing
We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient facilities prior to a scheduled surgery in the same Hospital provided that: the tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed; reservations for a Hospital bed and operating room were made prior to the performance of the tests; surgery takes place within seven days of the tests; and the patient is physically present at the Hospital for the tests.

9.19 Rehabilitation Services
We Cover Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition, per lifetime. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:
- Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- The therapy is ordered by a Physician; and
- You have been Hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation services must begin within six months of the later to occur:
- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

In no event will the therapy continue beyond 365 days after such event.

9.20 Second Opinions

- Second Cancer Opinion. We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-participating Provider on an In-Network basis when Your attending Physician provides a written Referral to a Non-Participating Specialist.
- Second Surgical Opinion. We Cover a second surgical opinion by a qualified Physician on the need for surgery.
- Required Second Surgical Opinion. We may require a second opinion before We Preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
    a. The second opinion must be given by a board certified Specialist who personally examines You.
    b. If the first and second opinions do not agree You may obtain a third opinion.
    c. The second and third surgical opinion consultants may not perform the surgery on You.
- Second Opinions in other Cases. There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will Preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

9.21 Surgical Services

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

Sometimes two or more surgical procedures can be performed during the same operation.

- Through the Same Incision. If Covered multiple surgical procedures are through the same incision, We will pay for the procedure with the highest Allowed Amount.

- Through Different Incisions. If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
    a. For the procedure with the highest Allowed Amount; and
    b. 50% of the amount We would otherwise pay for the other procedures.

9.22 Oral Surgery

We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.

- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

9.23 Reconstructive Breast Surgery
We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

9.24 Other Reconstructive and Corrective Surgery
We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:
- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect; or
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

9.25 Transplants
We Cover only those transplants determined to be nonexperimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. We do not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program.

We do not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

SECTION X. ADDITIONAL BENEFITS, EQUIPMENT AND DEVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

10.1 Autism Spectrum Disorder

We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "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).

- **Screening and Diagnosis:** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
- **Assistive Communication Devices:** We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We will not Cover items, such as, but not limited to, laptops, desktop, or tablet computers. We Cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

  We cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not Covered; however, We Cover one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or for routine maintenance.
- **Behavioral Health Treatment:** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis 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.

Our Coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.

- **Psychiatric and Psychological Care**: We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.
- **Therapeutic Care:** We Cover 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 this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Contract.
- **Pharmacy Care**: We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Contract.

- **Limitations:** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for Persons With Developmental Disabilities shall not affect coverage under the Contract for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

  You are responsible for any applicable Deductible, Copayment, or Coinsurance provisions under this Contract for similar services. For example, any Deductible, Copayment, or Coinsurance that applies to physical therapy visits generally will also apply to physical therapy services Covered under this benefit; and any Deductible, Copayment, or Coinsurance for Prescription Drugs generally will also apply to Prescription Drugs Covered under this benefit. Any Deductible, Copayment, or Coinsurance that applies to Your Primary Care Physician office visits will apply to assistive communication devices Covered under this paragraph.

  Nothing in this Contract shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the New York Insurance Law or an individualized service plan pursuant to regulations of the New York State Office for Persons with Developmental Disabilities.

10.2 Diabetic Equipment, Supplies and Self-Management Education

We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the Education Law as described below:

10.2.1 Equipment and Supplies

We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other provider legally authorized to prescribe:

- Acetone Reagent Strips
- Acetone Reagent Tablets

- Alcohol or Peroxide by the pint
- Alcohol Wipes
- All insulin preparations
- Automatic Blood Lance Kit
- Blood Glucose Kit
- Blood Glucose Strips (Test or Reagent)
- Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the Pump
- Glucose Acetone Reagent Strips
- Glucose Reagent Strips
- Glucose Reagent Tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin Cartridge Delivery
- Insulin infusion devices
- Insulin Pump
- Lancets
- Oral agents such as glucose tablets and gels
- Glucagon for injection to increase blood glucose concentration
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

10.2.2 Self-Management Education

Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the referral of Your Physician or other health care provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

10.2.3 Limitations

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness.

10.3 Durable Medical Equipment and Braces
We Cover the rental or purchase of durable medical equipment and braces.

10.3.1 Durable Medical Equipment
Durable Medical Equipment is equipment which is:

- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repairs or replacement when made necessary by normal wear and tear. We do not Cover the cost of repairs or replacement that are the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

We do not Cover equipment designed for Your comfort or convenience (such as pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment) as they do not meet the definition of durable medical equipment.

10.3.2 Braces
We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repairs or replacement that are the result of misuse or abuse by You.

10.4 Hearing Aids
We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver.

Covered services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years.

Bone anchored hearing aids are Covered only if You have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

If You meet the criteria for a bone anchored hearing aid, Coverage is provided for one hearing aid per ear during the entire period of time the You are enrolled under this Contract. We Cover repair and/or replacements for a bone anchored hearing aid only for malfunctions.

10.5 Hospice
Hospice Care is available if Your primary attending Physician has certified that You have six months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210

days of Hospice Care. We also Cover five visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

10.6 Medical Supplies

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Contract. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Contract. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. Please see the Diabetic Supplies, Education and Self-Management Education section of this Contract for a description of diabetic supply Coverage.

10.7 Prosthetics

10.7.1 External Prosthetic Devices

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered under this Section of the Contract and are only covered under the Pediatric Vision Care section in this Contract.

We do not Cover orthotics.

We also Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

1. **External Prosthetic Devices for Adults.**
   For adults, We Cover the cost of one prosthetic device, per limb, per lifetime. We do not Cover the cost of repair or replacement.

2. **External Prosthetic Devices for Children.**
   For children, We Cover the cost of one prosthetic device, per limb, per lifetime. We Cover the cost of replacement for children, but only if the previous device has been outgrown. We do not Cover the cost of repairs.

10.7.2 Internal Prosthetic Devices

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This

includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

SECTION XI. INPATIENT SERVICES
(For other than Mental Health and Substance Use)

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

11.1 Hospital Services
We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special, and critical nursing care;
- Meals and special diets;
- The use of operating, recovery, and cystoscopic rooms and equipment;
- The use of intensive care, special care, or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations, and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and plaster casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech, and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.

11.2 Observation Services
We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. The services include use of a bed and periodic monitoring by nursing or other licensed staff.

11.3 Inpatient Medical Services
We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Contract.

11.4 Inpatient Stay for Maternity Care
We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery, and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage

period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Contract and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits that apply to home care benefits.

11.5 Inpatient Stay for Mastectomy Care
We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy, or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period time determined to be medically appropriate by You and Your attending Physician.

11.6 Autologous Blood Banking Services
We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

11.7 Rehabilitation Services
We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

1. such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
2. the therapy is ordered by a Physician; and
3. You have been Hospitalized or have undergone surgery for such illness or injury.

Covered Services must begin within six months of the latter to occur:

1. the date of the injury or illness that caused the need for the therapy;
2. the date You are discharged from a Hospital where surgical treatment was rendered; or
3. the date outpatient surgical care is rendered.

11.8 Skilled Nursing Facility
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent, or domiciliary care is not Covered (see the Exclusions and Limitations section of this Contract). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to 200 days per Plan Year for non-custodial care.

11.9 End of Life Care
If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Contract until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.

2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute Care rate.

3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute Care rate.

11.10 Limitations/Terms of Coverage

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.

2. We do not Cover radio, telephone, and television expenses, or beauty or barber services.

3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for you to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

SECTION XII. MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

12.1 Mental Health Care Services

A. Inpatient Services

We Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous, and emotional disorders comparable to other similar Hospital, medical, and surgical coverage provided under this Contract. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10) such as:

1. A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
2. A state or local government run psychiatric inpatient Facility;
3. 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;
4. 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.

We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

B. Outpatient Services

We Cover outpatient mental health care services, including but not limited to partial Hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes 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; and services provided by a psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; [a licensed mental health counselor;] [a licensed marriage and family therapist;] [a licensed psychoanalyst;] or a professional corporation or a university faculty practice corporation thereof.

C. Limitations/Terms of Coverage

We do not Cover:

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.
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 the New York Office of Children and Family Services.
c. Services solely because they are ordered by a court.

12.2 SUBSTANCE USE SERVICES

A. Inpatient Services

We Cover inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency. This includes Coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York 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 or which are accredited by the Joint Commission as alcoholism, substance abuse, or chemical dependence treatment programs.

We also Cover inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities defined in 14 NYCRR 819.2(a)(1) and to services provided in such Facilities in accordance with 14 NYCRR Parts 817 and 819; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

B. Outpatient Services

We Cover outpatient substance use services relating to the diagnosis and treatment of alcoholism , substance use and dependency, including methadone treatment. Such 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 accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. 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..

We also Cover up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family Contract that covers the person receiving, or in need of, treatment for substance use, and/or dependency. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

SECTION XIII. PRESCRIPTION DRUG COVERAGE

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

13.1 Covered Outpatient Prescription Drugs

We Cover Medically Necessary Outpatient Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria.
- Non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen 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, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Contract.
- 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 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.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Prescription Drugs for smoking cessation.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

You may request a copy of Our drug formulary. Our drug formulary is also available on Our website at[http://healthrepublicny.org/current-documents/formulary/]. You may also inquire if a specific drug is Covered under this Contract by contacting us at the number on Your ID card.

13.2 Refills

We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order or Designated pharmacy as ordered by an authorized Provider, and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. 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 in the Schedule of Benefits section of this Contract.

13.3 Benefit and Payment Information

A. **Cost-Sharing Expenses:** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Contract when Covered Prescription Drugs are obtained from a retail or mail order or Designated pharmacy.

   You have a three tier plan design, which means that Your Out-of-Pocket Expenses will generally be lowest for Prescription Drugs on Tier 1 and highest for Prescription Drugs on Tier 3. Your Out-of-Pocket Expense for Prescription Drugs on Tier 2 will generally be more than for Tier 1 but less than Tier 3.

   You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

B. **Participating Pharmacies:** For Prescription Drugs purchased at a retail or mail order or designated Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required In-Network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at [888-990-5702] or visit our website at [http://healthrepublicny.org] to request approval.

C. **Non-Participating Pharmacies:** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

D. **Designated Pharmacies:** If You require certain Prescription Drugs including, but not limited to, specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused, or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, You will not have Coverage for that Prescription Drug.

Following are the therapeutic classes of Prescription Drugs that are included in this program:

- Age related macular edema
- Anemia, neutropenia, thrombocytopenia
- Contraceptives
- Crohn's Disease
- Cystic Fibrosis
- Cytomegalovirus
- Endocrine disorders/Neurologic disorders such as infantile spasms
- Enzyme Deficiencies/Liposomal Storage Disorders
- Gaucher's Disease
- Growth Hormone
- Hemophilia
- Hepatitis B, Hepatitis C
- Hereditary Angioedema
- HIV/AIDS
- Immune Deficiency
- Immune Modulator
- Infertility
- Iron Overload
- Iron Toxicity
- Multiple Sclerosis
- Oral Oncology
- Osteoarthritis
- Osteoporosis
- Parkinson's Disease
- Pulmonary Arterial Hypertension
- Respiratory Condition
- Rheumatologic and related conditions (Rheumatoid Arthritis, Psoriatic Arthritis,Ankylosing Spondylitis, Juvenile Rheumatoid Arthritis, Psoriasis)
- Transplant
- RSV Prevention

E. **Mail Order:** Certain Prescription Drugs may be ordered through Our mail order supplier. Other drugs may also be purchased at a mail order pharmacy. You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

To maximize Your benefit, ask Your Physician to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three Refills). You will

be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order supplier regardless of the number of days supply written on the Prescription Order or Refill.

Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy, including maintenance drugs when that retail pharmacy has a participation agreement with Us or Our vendor in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at [http://healthrepublicny.org/current-documents/formulary/] or by calling the Customer Service number on Your ID card. The maintenance drug list is updated periodically. Visit our website or call the Customer Service number on Your ID card to find out if a particular drug is on the maintenance list.

F. **Tier Status:** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six times per calendar year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at [https://newyork.healthrepublic.us] or by calling the Customer Service number on Your ID card.

G. **When a Brand-Name Drug Becomes Available As a Generic:** When a Brand-Name Drug becomes available as a Generic, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded due to a generic becoming available You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in the Utilization Review and External Appeals sections of the Contract.

H. **Formulary Exception Process**: If a Prescription Drug is not on Our Formulary, You may request a Formulary exception for a clinically-appropriate Prescription Drug. Visit Our website at [http://healthrepublicny.org] or call the Customer Service number on Your ID card.

Expedited Review of a Formulary Exception. You, Your designee or Your prescribing Health Care Professional may request an expedited review of a Formulary exception for a clinically appropriate Prescription Drug not on Our Formulary, in writing, electronically or telephonically, if You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-formulary Prescription Drug. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process and that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. We will make a decision and notify You or Your designee and the prescribing Health Care Professional no later than 24 hours after Our receipt of Your request. If We approve the request, We will cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum

function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

I. **Supply Limits:** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one Cost-Sharing amount for up to a 30-day supply. However, for maintenance drugs we will pay for up to a 90-day supply of a drug purchased at a retail pharmacy. You are responsible for up to three Cost-Sharing amounts for a 90-day supply at a retail pharmacy.

Benefits will be provided for drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one Cost-Share amount for a 30-day supply up to a maximum of two and a half Cost-Share amounts for a 90-day supply.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at [http://healthrepublicny.org] or by calling Customer Service at the telephone number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeals sections of the Contract.

J. **Cost-Sharing for Orally-Administered Anti-cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the Schedule of Benefits section of this Contract or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under the Outpatient and Professional Services section of this Contract.

13.4. Medical Management

This Contract includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

A. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug.

For a list of Prescription Drugs that need Preauthorization, please visit our website at [http://healthrepublicny.org/current-documents/formulary/] or call the Customer Service number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or of any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification including if a Prescription Drug or related item on the list does is not Covered under Your Contract. Your Provider may check with Us to find out which Prescription Drugs are Covered.

B. **Step Therapy**. Step therapy is a process in which You may need to use one type of Prescription Drug before We will Cover another as Medically Necessary. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. The Prescription Drugs that require

preauthorization under the Step Therapy Program are also included on the preauthorization drug list.

C. **Therapeutic Substitution.** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website at [http://healthrepublicny.org] or call the Customer Service at the phone number on Your ID Card.

13.5 Limitations/Terms of Coverage

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

B. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You don't make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

C. Compounded Prescription Drugs will be Covered only when they contain at least one ingredient that is a Covered legend Prescription Drug and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs require You to obtain Preauthorization.

D. 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.

E. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies are not Covered under this Section but are Covered under other Sections of this Contract.

F. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under Outpatient and Professional Services section of this Contract.

G. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs or as otherwise provided in this Contract. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

H. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

I. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

J. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Contract.

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

13.6. General Conditions

A. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug, or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

B. **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, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage. We may, from time-to-time, also enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors, or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member'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, 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 Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

13.7 DEFINITIONS

Terms used in this Section are defined as follows. (Other defined terms can be found in the "Definitions" Section of this Contract).

Brand-Name Drug: A Prescription Drug that (1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as a "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as Brand-Name Drug by Us.

Designated Pharmacy: A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

Formulary: The list that identifies those Prescription Drugs for which Coverage may be available under this Contract. This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website at [http://healthrepublicny.org/current-documents/formulary/] or by calling the Customer Service number on Your ID card.

Generic Drug: A Prescription Drug that (1) is chemically equivalent to a Brand-Name Drug; or (2) that We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as a "generic" by the manufacturer, pharmacy, or Your Physician may not be classified as a Generic Drug by Us.

Non-Participating Pharmacy: A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

Participating Pharmacy: A pharmacy that has:

- entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
- agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
- has been designated by Us as a Participating Pharmacy.

A Participating Pharmacy can be either a retail or mail-order pharmacy.

Prescription Drug: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Prescription Drug Cost: The rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Contract includes Coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

Prescription Order or Refill: The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.

Usual and Customary Charge: The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by Section 6826-a of the New York Education Law.

SECTION XIV. WELLNESS BENEFITS

14.1 Exercise Facility Reimbursement

We will partially reimburse the Subscriber and the Subscriber's Covered Spouse for certain exercise facility fees or membership fees, but only if such fees are paid to exercise facilities that We have an agreement with, and which maintain equipment and programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual work-out visits. We will not provide reimbursement for equipment, clothing, vitamins, or other services that may be offered by the facility (massages, etc.).

In order to be eligible for reimbursement, You must:

- be an active member of the exercise facility, and
- complete 50 visits in a six-month period.

In order to obtain reimbursement, at the end of the six-month period You must submit:

- a completed reimbursement form. Each time You visit the exercise facility, a facility representative must sign and date the reimbursement form.
- a copy of Your current facility bill which shows the fee paid for Your membership.

Once We receive the completed reimbursement form and the bill, You will be reimbursed the lesser of $200 for the Subscriber and $100 for the Subscriber's Spouse or the actual cost of the membership per six-month period.

SECTION XV. PEDIATRIC VISION CARE

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

15.1 Pediatric Vision Care

We Cover emergency, preventive, and routine vision care for Children up to age 19.

15.2 Vision Examinations

We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover one vision examination one time in any twelve (12) month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Opthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

15.3 Prescribed Lenses & Frames

We Cover standard prescription lenses or contact lenses once in any twelve (12) month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames adequate to hold lenses once in any twelve (12) month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. If you choose a non-standard frame, We will pay the amount that We would have paid for a standard frame and You will be responsible for the difference in cost between the standard frame and the non-standard frame. The difference in cost does not apply toward Your Out-of-Pocket Limit.

SECTION XVI. EXCLUSIONS AND LIMITATIONS

No Coverage is available under this Contract for the following:

16.1 Aviation
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

16.2 Convalescent and Custodial Care
We do not Cover services related to rest cures, custodial care and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting, and other such related activities. Custodial care does not include Covered services determined to be Medically Necessary.

16.3 Cosmetic Services
We do not Cover cosmetic services, Prescription Drugs, or surgery except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to, or follows surgery resulting from, trauma, infection, or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Contract. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (for example, certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Contract unless medical information is submitted.

16.4 Coverage Outside of the United States, Canada or Mexico
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and Ambulance services to treat Your Emergency Condition.

16.5 Dental Services
We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as specifically stated in the Outpatient and Professional Services section of this Contract.

16.6 Experimental or Investigational Treatment
We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Contract for non-investigational treatments. See Section IX of this Contract for a further explanation of Your Appeal rights.

16.7 Felony Participation
We do not Cover any illness, treatment, or medical condition due to Your participation in a felony, riot, or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

16.8 Foot Care
We do not Cover routine foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet. However, We will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet

16.9 Government Facility
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law, unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

16.10 Medically Necessary
In general, We will not Cover any health care service, procedure, treatment, device, or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device, or Prescription Drug for which Coverage has been denied, to the extent that such service, procedure, treatment, test, device, or Prescription Drug is otherwise Covered under the terms of this Contract.

16.11 Medicare or Other Governmental Program
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

16.12 Military Service
We do not Cover an illness, treatment, or medical condition due to service in the Armed Forces or auxiliary units.

16.13 No-Fault Automobile Insurance
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. 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.

16.14 Services not Listed
We do not Cover services that are not listed in this Contract as being Covered.

16.15 Services Provided by a Family Member
We do not Cover services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your spouse.

16.16 Services Separately Billed by Hospital Employees
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

16.17 Services With No Charge
We do not Cover services for which no charge is normally made.

16.18 Vision Services
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section of this Contract.

16.19 War
We will not Cover an illness, treatment, or medical condition due to war, declared or undeclared.

16.20 Workers' Compensation
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability, or occupational disease law.

SECTION XVII. CLAIM DETERMINATION

17.1 Claims
A claim is a request that benefits or services be provided or paid according to the terms of this Contract. When You receive services from a Participating Provider you will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

17.2 Notice of Claim
Claims for services 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, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the Provider making the charge, 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. Claim forms are available from Us by calling the number on your ID card or visiting Our website at [http://healthrepublicny.org]. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Contract or on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Contract; on Your ID card or visiting Our website [http://healthrepublicny.org/for-members/find-a-provider/].

17.3 Timeframe for Filing Claims
Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days period, You must submit it as soon as reasonably possible.

17.4 Claims for Prohibited Referrals
We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services, or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law § 238-a(1).

17.5 Claim Determinations
Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies to Referrals and contractual benefit denials. If You disagree with Our claim determination you may submit a Grievance pursuant to the Grievance section of this Contract.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Contract.

17.6 Pre-service Claim Determinations
1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (for example a Referral or a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

   If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing,

within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Pre-service Reviews**
   With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone within 72 hours of receipt of the request. Written notice will follow within three calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period. Written notice will follow within three calendar days of the decision.

17.7 Post-service Claim Determinations

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

SECTION XVIII. GRIEVANCE PROCEDURES

18.1 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.

18.2 Filing a Grievance

You can contact Us by phone at [888-990-5702] or in writing to file a Grievance. You must use Our Grievance form for written Grievances. You may submit an oral Grievance in connection with a denial of a referral or a Covered benefit determination. 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'll take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

18.3 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 are not in relation to a claim or request for service.)	In writing, within 30 calendar days of receipt of Your Grievance.

18.4 Assistance
If You remain dissatisfied with Our Grievance 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

If You need assistance filing a Grievance or Appeal You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org

SECTION XIX. UTILIZATION REVIEW

19.1 Utilization Review

We review 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 performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by 1) licensed Physicians or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the health care Provider who typically manages Your medical condition or disease or provides the health care service under review, or 3) with respect to substance use disorder treatment, effective on the date of issuance or renewal of this Contract, on or after April 1, 2015, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. 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 upon request. For more information, You can contact Us or visit our website at [http://healthrepublicny.org].

19.2 Preauthorization Reviews

If We have all the information necessary to make a determination regarding a Preauthorization 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 3 business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, 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 Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

19.3 Urgent Preauthorization Reviews

With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three business days of the decision. 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 (or Your designee) 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.

19.4 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 necessary information. If We need additional information, We will request it within one business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your

Provider, by telephone and in writing, within one business day of Our receipt of the information or, if We do not receive the information, within 1 business day of the end of the 45-day time period.

19.5 Urgent Concurrent Reviews
For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one business day of receipt of the request. If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one business day 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 written notice to You (or Your designee) and Your Provider within the earlier of one business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour time period.

19.6 Home Health Care Reviews.
After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

19.7 Inpatient Substance Use Disorder Treatment Reviews.
Effective on the date of issuance or renewal of this Contract on or after April 1, 2015, if a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

19.8 Retrospective Reviews
If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. 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 in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

Once We have all the information to make a decision, Our failure to make a Utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

19.9 Retrospective Review of Preauthorized Services
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;

- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

19.10 Reconsideration
If We did not attempt to consult with Your Provider before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

19.11 Utilization Review Internal Appeals
You, Your designee, and, in retrospective review cases, Your 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 a Physician or a Health Care Professional 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.

Out-of-Network Service Denial. You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. You are not eligible for a Utilization Review Appeal if the service you request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating your condition. (Such an Appeal will be treated as a Grievance.) For a Utilization Review Appeal of denial of an Out-of-Network health service, You, or Your designee, must submit:

1. A written statement from Your attending Physician, who must be a licensed, board-certified, or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested Out-of-Network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
2. Two documents from the available medical and scientific evidence that the Out-of-Network service:
   (a) Is likely to be more clinically beneficial to You than the alternate In-Network service; and
   (b) that the adverse risk of the Out-of-Network service would likely not be substantially increased over the In-Network health service.

Out-of-Network Referral Denial. Beginning April 1, 2015, You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care

needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:

1. That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
2. Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

19.12 Standard Appeal

Preauthorization Appeal. If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and, where appropriate, Your Provider, within two 2 business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

Retrospective Appeal. If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeals

An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, 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 earlier of 72 hours from receipt of the Appeal or two business days of receipt of the information necessary to conduct the Appeal.

Our failure to render a determination of Your Appeal within sixty 60 calendar days of receipt of the necessary information for a standard Appeal or within two business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

Substance Use Appeal. Effective on the date of issuance or renewal of this Contract on or after April 1, 2015, if We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

19.13 Appeal Assistance

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail: cha@cssny.org

SECTION XX. EXTERNAL APPEALS

20.1 Your Right to an External Appeal

In some cases, You have a right to an external appeal of a denial of coverage. Specifically, if We have denied coverage on the basis that a service does not meet Our requirements for Medical Necessity (including appropriateness, health care setting, level of care, or effectiveness of a Covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Contract, and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
  - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
  - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
  - We fail to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control, and the violation occurred during an ongoing, good faith exchange of information between You and Us).

20.2 Your Right to Appeal a Determination that a Service is Not Medically Necessary

If We have denied coverage on the basis that the service does not meet Our requirements for Medical Necessity, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in 20.1, above.

20.3 Your Right to Appeal a Determination that a Service is Experimental or Investigational

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two requirements for an external appeal in 20.1, above, and Your attending Physician must certify that Your condition or disease is one for which : (1) standard health services are ineffective or medically inappropriate; **or** (2) there does not exist a more beneficial standard service or procedure Covered by Us; **or** (3) there exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one of the following:

- A service, procedure, or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
  A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this Section, Your attending Physician must be a licensed, board-certified, or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

20.4 Your Right to Appeal a Determination that a Service is Out-of-Network
If We have denied coverage of an Out-of-Network treatment because it is not materially different than the health service available In-Network, You may appeal to an External Appeal Agent if You meet the two requirements for an external appeal in I above, and You have requested preauthorization for the Out-of-Network treatment.

In addition, Your attending Physician must certify that the Out-of-Network service is materially different from the alternate recommended In-Network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate In-Network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate In-Network health service.

For purposes of this Section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

[You do not have a right to an external appeal for a denial of a Referral to an Out-of-Network provider on the basis that a health care provider is available In-Network to provide the particular health service requested by You.]

20.5 Your Right to Appeal an Out-of-Network Referral Denial
Beginning April 1, 2015, if We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two requirements for an external appeal in paragraph 20.1 above.

In addition, Your attending Physician must: certify that The Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

20.6 The External Appeal Process
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited appeal (described below), We do not have a right to reconsider Our decision.

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

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health, or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

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

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

We will charge You a fee of $25 for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

20.7 Your Responsibilities

It is Your RESPONSIBILITY to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XXI. TERMINATION OF COVERAGE

This Contract may be terminated as follows:

21.1 Automatic Termination of this Contract

This Contract shall automatically terminate upon the death of the Subscriber, unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, this Contract will terminate as of the last day of the month for which the Premium has been paid.

21.2 Automatic Termination of Your Coverage

1. Coverage under this Contract shall automatically terminate:
    a. For Spouses in cases of divorce, the date of the divorce.
    b. For Children, the end of the month in which the Child turns 26 years of age. F
    c. For all other Dependents, the end of the month in which the Dependent ceases to be eligible, except that We shall not terminate Your Dependent if Your Dependent becomes eligible for or enrolls in Medicare.

Eligibility or enrollment in Medicare is not a basis for termination under this Contract.

21.3 Termination by You

The Subscriber may terminate this Contract at any time by giving the NYSOH at least 14 days prior written notice.

21.4 Termination by Us

We may terminate this Contract with 30 days' written notice as follows:

1. Non-Payment of Premiums.
   Premiums are to be paid by the Subscriber to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:
    a. If the Subscriber does not receive advanced payments of the premium tax credit for coverage in the NYSOH and fails to pay the required Premium within a 30-day grace period, this Contract will terminate retroactively back to the last date Premiums were paid. The Subscriber will be responsible for paying any claims submitted during the grace period if this Contract terminates.
    b. If the Subscriber receives advanced payments of the premium tax credit and has paid at least one full month's Premium, this Contract will terminate one month after the last day Premiums were paid. That is, retroactive termination will not exceed 61 days. We may pend claims incurred during the 61-day grace period. The Subscriber will be responsible for paying any claims incurred during the 61-day grace period if this Contract terminates.
2. Fraud or Intentional Misrepresentation of Material Fact.
   If the Subscriber has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, this Contract will terminate immediately upon a written notice to the Subscriber from the NYSOH. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue this Contract and the application is attached to this Contract. Rescission means that the termination of Your coverage will have a retroactive effect of up to the issuance of this Contract.

3. If You no longer live or reside in Our Service Area.

4. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide the Subscriber with at least five months' prior written notice.

5. The date the Contract is terminated because We terminate or cease offering all hospital, surgical and medical expense coverage in the individual market, in this State. We will provide the Subscriber with at least 180 days prior written notice.

No termination of coverage shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Conversion Right to a New Contract After Termination section of this Contract for Your right to conversion to another individual Contract.

SECTION XXII. EXTENSION OF BENEFITS

22.1 EXTENSION OF BENEFITS

When Your coverage under this Contract ends, benefits stop. But, if You are totally disabled on the date the Contract terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability.

For purposes of this Section, total disability means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

22.1.1. When You May Continue Benefits

If You are totally disabled on the date Your coverage under this Contract terminates, We will continue to pay for Your care under this Contract during an uninterrupted period of total disability until the first of the following:

- The date You are no longer totally disabled.
- 12 months from the date this Contract terminated.

22.1.2. Limits on Extended Benefits

We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Contract ends.
- Beyond the extent to which We would have paid benefits under this Contract if coverage had not ended.

SECTION XXIII TEMPORARY SUSPENSION RIGHTS FOR ARMED FORCES' MEMBERS

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and
2. You serve no more than five years of active duty.

You must make written request to Us to have Your coverage suspended during a period of active duty. Your unearned premiums will be refunded during the period of such suspension.

Upon completion of active duty, Your coverage may be resumed as long as You:

1. make written application to Us; and
2. Remit the premium within 60 days of the termination of active duty.

The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XXIV. CONVERSION RIGHT TO NEW CONTRACT AFTER TERMINATION

24.1 Circumstances Giving Rise to Right to Conversion
The Subscriber's Spouse and Children have the right to convert to a new Contract if their coverage under this Contract terminates under the circumstances described below.

A. **Termination of Your Marriage.** If a Spouse's coverage terminates under the Termination of Coverage section of this Contract because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.

B. **Termination of Coverage of a Child.** If a Child's coverage terminates under the Termination of Coverage section of this Contract because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.

C. **On the Death of the Subscriber.** If coverage terminates under the Termination of Coverage section of this Contract because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

24.2 When to Apply for the New Contract
If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 60 days after termination of Your coverage under this Contract. You must also pay the first Premium of the new Contract at the time You apply for coverage.

24.3The New Contract
We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. You may choose among any of the four Contracts offered by Us.

SECTION XXV. GENERAL PROVISIONS

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

2. **Assignment.** You cannot assign any monies due under this Contract to any person, corporation or other organization unless it is an assignment to Your Physician for a surprise bill for Covered Services provided on and after April 1, 2015. See the How Your Coverage Works section of this Contract for more information about surprise bills. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Contract or your right to collect money from us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

3. **Changes in This Contract.** We may unilaterally change this Contract upon renewal, if We give You 45 days' prior written notice.

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

5. **Clerical Error.** Clerical error, whether by You or Us, with respect to this Contract, or any other documentation issued by Us in connection with this Contract, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. **Conformity with Law:** Any term of this Contract which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. **Continuation of Benefit Limitations.** Some of the benefits under this Contract may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the Year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when you were a covered family member will be applied toward your new status as a Subscriber.

8. **Entire Agreement.** This Contract, including any endorsements, riders and the attached applications, if any, constitutes the entire Contract.

9. **Furnishing Information and Audit.** All persons covered under this Contract will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. 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.

10. **Identification Cards.** Identification ("ID") cards are issued by Us for identification only. Possession of any identification card confers no right to services or benefits under this Contract.

To be entitled to such services or benefits Your Premiums must be paid in full at the time that the services are sought to be received.

11. **Incontestability.** All statements contained in any such written instrument shall be deemed representations and not warranties.

    No statement by the Subscriber in an application for coverage under this Contract shall avoid the Contract or be used in any legal proceeding unless the application or an exact copy is attached to this Contract. After two years from the date of issue of this Contract no misstatements, except for fraudulent misstatements made by the Subscriber in the application for coverage shall be used to void the Contract or deny a claim.

12. **Independent Contractors**. Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your Covered Spouse, or Children while receiving care from any Participating Provider or in any Participating Provider's facility.

13. **Input in Developing Our Policies.** Health Republic is committed to member-led healthcare. Our mission guarantees that members are at the center of everything we do. As a Consumer Operated and Oriented Plan (CO-OP), we hold Member Director elections annually in September, where our members will elect other members to the Board, with Member Directors making up a majority beginning in January 2015. Our Member Directors will participate in quarterly Board meetings, annual membership meetings and committee work. They will be responsible for overseeing Health Republic, including setting policies and guiding decision-making for the plan. Our member focused participation initiatives also include the formation of Member Advisory Groups, encouraging members to share their voice on important issues, policies, and plan features. Additionally we will continue to seek member input through quarterly satisfaction surveys, member newsletters, online comment mailboxes, and social media channels.

14. **Material Accessibility.** We will give You ID cards, Contracts, riders, and other necessary materials.

15. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Contract. Upon Your request, We will provide the following information:
    - A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
    - The information that We provide the State regarding Our consumer complaints.
    - A copy of Our procedures for maintaining confidentiality of Member information.
    - A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Contract.
    - A written description of Our quality assurance program.
    - A copy of Our medical Contract regarding an experimental or investigational drug, medical device or treatment in clinical trials.
    - Provider affiliations with Participating Hospitals.
    - A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.

- Written application procedures and minimum qualification requirements for Providers.

16. **Notice.** Any notice that We give to You under this Contract will be mailed to Your address as it appears on our records. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: Health Republic Insurance of New York, [30 Broad Street, 34th Floor, New York NY 10004]. You may also upload it via the secured member section of our website at [http://healthrepublicny.org].

17. **Premium Payment**: The initial premium is payable one month in advance by the Subscriber to Us at Our office. The first month's premium is due and payable upon submission of the application. Coverage will begin on the effective date of the Contract as defined herein. Subsequent premiums are due and payable on the first of each month thereafter.

18. **Premium Refund.** We will give any refund of Premiums, if due, to the Subscriber.

19. **Recovery of Overpayments.** On occasion a payment will be made to You 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. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

20. **Renewal Date.** The renewal date for the Contract is January 1 of each Year. This Contract will automatically renew each year on the renewal date unless otherwise terminated by Us as permitted by the Contract, or by the Subscriber upon 30 days' prior written notice to Us.

21. **Reinstatement After Default.** If You default in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Contract.

22. **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 Contract. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether surgery was Medically Necessary to treat Your illness or injury; or whether certain services are skilled care. Those standards will not be contrary to the descriptions in this Contract. If You have a question about the standards 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 Contract.

23. **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 owe to Us. Except as otherwise required by law, 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.

24. **Severability.** The unenforceability or invalidity of any provision of the Contract shall not affect the validity and enforceability of the remainder of the Contract.

25. **Significant Change in Circumstances**. If We are unable to arrange for Covered Services as provided under this Contract as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

26. **Subrogation and Reimbursement.** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness, or other condition and We have provided benefits related to that injury, illness, or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Contract. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

    Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if you or anyone on your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under Section 5—335 of the New York General Obligations Law, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

    We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by You for which we have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

27. **Third Party Beneficiaries:** No third party beneficiaries are intended to be created by this Contract and nothing in this Contract shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Contract. No other party can enforce this Contract's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Contract, or to bring an action or pursuit for the breach of any terms of this Contract.

28. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Contract. You must start any lawsuit against Us under this Contract within 2 years from the date the claim was required to be filed.

29. **Translation Services.** Translation services are available under this Contract for non-English speaking Members. Please contact us at [888-990-5702] to access these services.

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

31. **Waiver.** The waiver by any party of any breach of any provision of the Contract will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

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

33. **Who Receives Payment under This Contract.** Payments under this Contract for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.

34. **Workers' Compensation Not Affected.** The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

35. **Your Medical Records and Reports.** In order to provide Your coverage under this Contract, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, 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. By accepting coverage under this Contract, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:
    - Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to 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;
    - Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
    - Permit copying of Your medical records by Us.

    We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your 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 Contract, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

Exhibit 2

(Sample HRINY Group Policy)

HEALTH REPUBLIC
INSURANCE

This is Your

EXCLUSIVE PROVIDER ORGANIZATION
CERTIFICATE OF COVERAGE

Issued by
Freelancers Health Service Corporation
DBA Health Republic Insurance of New York
30 Broad Street 34th Floor
New York, New York 10004

To

Group contract holder

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between Freelancers Health Service Corporation DBA Health Republic Insurance of New York (hereinafter referred to as "We", "Us", or "Our") and the Group contractholder 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 only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in our MagnaCare[sm] Extra Network. Except for care for an Emergency Condition (described in Section VI) You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

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.

This Certificate is governed by the laws of New York State.

Signed by: Debra Friedman
Debra Friedman
Chief Executive Officer

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SECTION I - DEFINITIONS

Defined terms will appear capitalized throughout the Certificate.

Acute: The sudden onset of disease or injury, or a sudden change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See Section IV of this Certificate for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: This Certificate issued by Freelancers Health Service Corporation DBA Health Republic Insurance of New York, including the Schedule of Benefits and any attached riders.

Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the "Who is Covered" Section of this Certificate.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Coinsurance, Copayments, and/or Deductibles.

Cover, Covered, or Covered Services: The Medically Necessary services paid for or arranged for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Coinsurance or Copayments are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Durable Medical Equipment (DME): Durable Medical Equipment is equipment which is:

- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the Department of Financial Services to perform external appeals in accordance with New York law.

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; a comprehensive care center for eating disorders pursuant to article 27-J of the public health law; an institutional Provider of mental health or chemical dependence and abuse treatment operating under Article 31 of the New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or other Provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable). If You receive treatment for chemical dependence or abuse outside of New York State, the Facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") to provide a chemical abuse treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an Agreement with Us.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy, and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; osteopath; dentist; optometrist; chiropractor; psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist certified to administer immunizing agents; or any other licensed, registered or certified Health Care Professional under Title 8 of the Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within

the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- if located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861(k) of United States Public Law 89-97 (42 U.S.C. § 1395x(k));
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

Medically Necessary: See Section II of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber and Covered Dependents for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. The services of Non-Participating Providers are Covered only for Emergency Services or when authorized by Us.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at http://newyork.healthrepublic.us/network or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The 12-month period beginning on the effective date of the Certificate or any anniversary date thereafter, during which the Certificate is in effect.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the "Schedule of Benefits" Section of this Certificate.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Primary Care Physician: A Participating Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who typically is an internal medicine, family practice, or pediatric doctor and who directly provides or coordinates a range of health care services for You.

Provider: A Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), licensed Health Care Professional or Facility licensed, certified or accredited as required by state law.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The Section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Maximums, Preauthorization requirements and other limits on Covered Services.

Service Area: The geographical area designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of the following counties: Albany, Bronx, Brooklyn, Chautauqua, Columbia, Delaware, Dutchess, Erie, Essex, Greene, Hamilton, Monroe, Nassau, New York, Niagara, Onandaga, Ontario, Orange, Orleans, Putnam, Queens, Rensselaer, Rockland, Saratoga, Schenectady, Staten Island, Suffolk, Sullivan, Ulster, Warren, Washington, and Westchester.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare law; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse.

Subscriber: The person to whom this Certificate is issued.

UCR (**Usual, Customary, and Reasonable):** The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency department care. Urgent Care may be rendered in a Participating Physician's office or Urgent Care Center

Urgent Care Center: A licensed Facility (except Hospitals) that provides Urgent Care.

Us, We, Our: Freelancers Health Service Corporation DBA Health Republic Insurance of New York and anyone to whom We legally delegate to perform, on Our behalf, under the Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II - HOW YOUR COVERAGE WORKS

2.1 Your Coverage under this Certificate
Your employer (referred to as the "Group contract holder") has purchased a Group Contract from Us. We will provide the benefits described in this Certificate to members of the Group, that is, to employees of the Group and their Covered Dependents. 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.

2.2 Covered Services
You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits in Section XIV of this Certificate; and
- Received while Your Certificate is in force.

2.3 Participating Providers
To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request.
- Call Member Services.
- Visit our website http://newyork.healthrepublic.us/network.

However, You may need to request Preauthorization before You receive certain services. See the Schedule of Benefits in Section XIV of this Certificate for the services that require Preauthorization.

2.4 The Role of Primary Care Physicians
This Certificate does not have a gatekeeper, usually known as the Primary Care Physician (PCP). You do not need a Referral from a PCP before receiving Specialist care from a Participating Provider.

2.5. Services Subject To Preauthorization
Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network services listed in the Schedule of Benefits in Section IV of this Certificate.

2.6 Preauthorization / Notification Procedure
If You seek coverage for services that require Preauthorization or notification, You must call Us at the number indicated on Your ID card.

You must contact Us to request Preauthorization as follows:

- At least two weeks prior to a planned admission or surgery when Your Provider recommends inpatient
- Hospitalization. If that is not possible, then during regular business hours prior to the admission.
- At least two weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider
- recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in a
- free standing Ambulatory Surgical Center.
- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.

- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources including medical policy , clinical guidelines, and pharmacy and therapeutic guidelines.

2.7 Failure to Seek Preauthorization or Provide Notification

If You fail to seek Our Preauthorization or provide notification for benefits subject to this Section, We will pay an amount $500 less than We would otherwise have paid for the care, or We will pay only 50% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining charges. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization or provide notification. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

2.8 Medical Management

The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be provided.

2.9 Care Must Be Medically Necessary

We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription 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 Cover it.

We may base Our decision on a review of: Your medical records; Our medical policies and clinical guidelines; medical opinions of a professional society, peer review committee or other groups of Physicians; reports in peer-reviewed medical literature; reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data; professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment; the opinion of Health Care Professionals in the generally-recognized health specialty involved; and the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results;

- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

See Section IX of this Certificate for Your right to an internal appeal and external appeal of Our determination that a service is not Medically Necessary.

2.10 Important Telephone Numbers and Addresses

CLAIMS
*Submit claim forms to this address.
Health Republic Insurance of New York
P.O. Box 6329
Syracuse, NY 13217-6329

COMPLAINTS, GRIEVANCES, AND UTILIZATION REVIEW APPEALS
Health Republic Insurance of New York
2425 James Street
Syracuse, NY 13206
Phone: 888.990.5702
Fax: 315-433-5445

MEMBER SERVICES
* Member Services Representatives are available Monday – Friday 8:30 a.m. – 5:30 p.m. EST
Phone: 888.990.5702
Fax: 315-432-9442

PREAUTHORIZATION
Monday – Friday 8:00 a.m. – 6:00 p.m. EST
Phone: 888.990.5702
Fax: 315-433-5442

OUR WEBSITE
http://newyork.healthrepublic.us

SECTION III - ACCESS TO CARE AND TRANSITIONAL CARE

3.1 Referral to a Non-Participating Provider

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve a Referral to an appropriate Non-Participating Provider. Approvals of Referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider. Your Participating Provider or You must request prior approval of the Referral to a specific Non-Participating Provider. If We approve the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, Your Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

3.2 When Your Provider Leaves the Network

If You are in an ongoing course of treatment when Your Provider leaves Our Network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered services for up to ninety (90) days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-Network Cost-Sharing. Please note that if the Provider was terminated by Us 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.

3.3 New Members In a Course of Treatment

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to sixty (60) days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Certificate; becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered services for up to sixty (60) days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

SECTION IV - COST-SHARING EXPENSES AND ALLOWED AMOUNT

4.1 Deductible
Except where stated otherwise, You must pay the amount in the Schedule of Benefits in Section XIV of this Certificate for Covered Services during each Plan Year before We provide coverage. If You have other than Individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible. However, after Deductible payments for all persons covered under this Certificate total the family Deductible amount in the Schedule of Benefits in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

4.2 Copayments
Except where stated otherwise, after You have satisfied the annual Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits in Section XIV of this Certificate for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

4.3 Coinsurance
Except where stated otherwise, after You have satisfied the annual Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits in Section XIV of this Certificate.

4.4 Out-of-Pocket Limit
When You have met Your Out-of-Pocket Limit in payment of Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits in Section XIV of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If you have other than Individual coverage, the individual Out-of-Pocket Limit applies to each person covered under this Certificate. Once a person within a family meets the individual Out-of-Pocket Limit, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than Individual coverage applies, when members of the same family covered under this Certificate have collectively met the family Out-of-Pocket Limit in payment of Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year.

4.5 Allowed Amount
"**Allowed Amount**" means the maximum amount we will pay to a Provider for the services or supplies covered under this Certificate, before any applicable Deductible, Copayment, and Coinsurance amounts are subtracted. We determine our Allowed Amount as follows:

- The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider.

- See Section VI of the Certificate for the Allowed Amount for an Emergency Condition.

SECTION V - WHO IS COVERED

5.1 Who is Covered Under this Certificate

You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. You must live, work, or reside in Our Service Area to be covered under this Contract. If You selected one of the following types of coverage, members of Your family may also be covered.

5.2 Types of Coverage

In addition to Individual coverage, We offer the following types of coverage:

- Individual and Spouse – If You selected Individual and Spouse coverage, then You and Your Spouse are covered.

- Parent and Child/Children – If You selected Parent and Child/Children coverage, then You and Your Child or Children, as described below, are covered.

- Family – If You selected Family coverage, then You and Your Spouse and Your Children, as described below, are covered.

5.3 Children Covered Under This Certificate

If You selected Parent and Child/Children or Family coverage, "Children" covered under this Certificate include Your natural Children, legally adopted Children, step-Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status, or employment. A proposed adopted Child is eligible for coverage on the same basis as natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this Section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or Covered Subscriber and all other prospective or Covered Members as they pertain to eligibility for coverage under this Certificate at any time.

5.4 When Coverage Begins

Coverage under this Certificate will begin as follows:

- If You, the Subscriber elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your group. Groups cannot impose waiting periods that exceed 90 days.

- If You, the Subscriber do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the group's next open enrollment period to enroll, except as provided below.
- If You, the Subscriber, marry while covered, and the Exchange receives notice of such marriage within 30 days thereafter, coverage for Your Spouse starts on the first day of the month following such marriage. If the Exchange does not receive notice within 30 days of the marriage, You must wait until the group's next open enrollment period to add Your Spouse.
- If You, the Subscriber, have Family or Parent and Child/Children coverage, and have a newborn Child, and the Exchange receives notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth. If You have Individual or Individual and Spouse coverage, You must notify the Exchange of Your desire to switch to Parent and Child/Children or Family coverage and pay any additional premium within 30 days from the date of birth in order for coverage to start at the moment of birth; otherwise Parent and Child/Children or Family coverage begins on the date on which the Exchange receives notice.
- If You, the Subscriber, have Family or Parent and Child/Children coverage, Your adopted newborn Child will be covered from the moment of birth if You notify us within 30 days of the birth, You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law or other applicable state law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If You have Individual or Individual and Spouse coverage, You must also notify the Exchange of Your desire to switch to Parent and Child/Children or Family coverage and pay any additional premium within 30 days from the date of birth in order for coverage to start at the moment of birth. Otherwise Parent and Child/Children or Family coverage begins on the date on which the Exchange receives notice and the premium payment. However, We will not provide Hospital benefits for the newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay.

5.5 Special Enrollment Periods

You, Your Spouse, or Child, can also enroll for coverage within 30 days of the occurrence of one of the following events:

- You or Your Spouse or Child loses minimum essential coverage.
- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange as evaluated and determined by the Exchange.
- You adequately demonstrate to the Exchange that another qualified health plan in which You were enrolled substantially violated a material provision of its contract.
- You move and become eligible for new qualified health plans.
- If You are an Indian, as defined in 25 U.S.C. 450b(d), You may enroll in a qualified health plan or change from one qualified health plan to another one time per month.
- You demonstrate to the Exchange that You meet other exceptional circumstances as the Exchange may provide.

The Exchange must receive notice and premium payment within 30 days of one of these events. The effective date of Your coverage will depend on when the Exchange receives Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month. But, if You enroll because You lost minimum essential

coverage, Your coverage will begin on the first day of the month following Your loss of coverage.

In addition, You, Your Spouse, or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

- You or Your Spouse or Your Child loses eligibility for Medicaid or a state child health plan.
- You or Your Spouse or Your Child becomes eligible for Medicaid or a state child health plan.

The Exchange must receive notice and premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when the Exchange receives Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

SECTION VI – COVERED SERVICES

Preventive Care

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

6.1 PREVENTIVE CARE

We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles, and Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at 888-990-5702 or visit Our website at http://newyork.healthrepublic.us for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

6.1.1 Well-Baby and Well-Child Care

We Cover well-baby and well-child care which consist of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one well-child visit per calendar year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles, or Coinsurance when provided by a Participating Provider.

6.1.2 Adult Annual Physical Examinations

We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening, and diabetes screening. A complete list of the Covered preventive services is available on Our website at http://newyork.healthrepublic.us, or will be mailed to You upon request.

You are eligible for a physical examination once every Plan year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

6.1.3 Adult Immunizations

We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the recommendations of ACIP and when provided

by a Participating Provider.

6.1.4 Well-Woman Examinations
We Cover well-woman examinations which consist of a routine gynecological examination, breast examination, and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive services is available on Our website at http://newyork.healthrepublic.us, or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

6.1.5 Mammograms
We Cover mammograms for the screening of breast cancer as follows:

- one baseline screening mammogram for women age 35 through 39;
- one baseline screening mammogram annually for women age 40 and over.

If a woman of any age has a history of breast cancer or her first degree relative has a history of breast cancer, We Cover mammograms as recommended by her Provider. However, in no event will more than one preventive screening, per Plan Year, be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than the above schedule, and when provided by a Participating Provider.

Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are Covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to Copayments, Deductibles, or Coinsurance.

6.1.6 Bone Mineral Density Measurements or Testing
We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to Section VI of the Certificate. Bone mineral density measurements or tests, drugs, or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
- On a prescribed drug regimen posing a significant risk of osteoporosis; or
- With lifestyle factors to 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.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

6.1.7 Screening for Prostate Cancer

We Cover 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. We also Cover 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.

This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided by a Participating Provider.

6.2 PRE-HOSPITAL EMERGENCY MEDICAL SERVICES AND AMBULANCE SERVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service. We also Cover emergency ambulance transportation by a licensed ambulance service (either ground, water, or air ambulance) to the nearest Hospital where Emergency Services can be performed.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the N.Y. Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable Copayment, Coinsurance, or Deductible.

Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

6.2.1 Non-Emergency Ambulance Transportation:

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a Non-Participating Hospital to a Participating Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care Facility.

- From an acute Facility to a sub-acute setting.

See the schedule of benefits in Section XIV of this Certificate for any Preauthorization requirements for non-emergency transportation.

6.2.2 Limitations/Terms of Coverage:

Benefits do not include travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician. Non-ambulance transportation such as ambulette, van, or taxi cab is not Covered.

Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; **and** Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; **and** one of the following is met:

- The point of pick-up is inaccessible by land vehicle; or
- Great distances or other obstacles (for example, heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

6.3 EMERGENCY SERVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover Emergency Services for the treatment of an Emergency Condition.

We define an **Emergency Condition** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition 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;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain;
- Severe or multiple injuries;
- Severe shortness of breath;

- Sudden change in mental status (e.g., disorientation);
- Severe bleeding;
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis;
- Poisonings; or
- Convulsions.

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition.

We define **Emergency Services** to mean: Evaluation of an Emergency Condition and treatment to keep the condition from getting worse including:

- A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and

- Within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs.

6.3.1 Hospital Emergency Department Visits
In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition, as defined above, are Covered in an emergency department**. If You are uncertain whether this is the most appropriate place to receive care You can call Us before You seek treatment. Our Medical Management Coordinators are available 24 hours a day, 7 days a week. Your Coordinator will direct You to the emergency department of a Hospital or other appropriate Facility.

Follow-up care or routine care provided in a Hospital emergency department is not Covered. You should contact Us to make sure You receive the appropriate follow-up care.

6.3.2 Emergency Hospital Admissions
In the event You are **admitted** to the Hospital: You or someone on Your behalf must notify Us at the telephone number listed in this Certificate and on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

We Cover inpatient Hospital services at a Non-Participating Hospital for as long as Your medical condition prevents Your transfer to a Participating Hospital, unless We authorize continued treatment at the Non-Participating Hospital. If Your medical condition permits Your transfer to a Participating Hospital We will notify You and arrange the transfer. Any inpatient Hospital services received from a Non-Participating Hospital after

we have notified You and arranged for a transfer to a Participating Hospital will not be Covered. See Section IX of the Certificate for Your Appeal rights.

6.3.3 Payments Relating to Emergency Services Rendered
The amount We pay a Non-Participating Provider for Emergency Services will be the greater of: (1) the amount We have negotiated with Participating Providers for the Emergency Service received (and if more than one amount is negotiated, the median of the amounts); (2) 100% of the Allowed Amount for Services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or (3) the amount that would be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

You are responsible for any Deductible, Coinsurance, or Copayment.

6.3.4 Urgent Care
Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. **We do not cover Urgent Care from Non-Participating Urgent Care Centers or Physicians**.

A. In-Network
You may obtain Urgent Care from a Participating Physician or a Participating Urgent Care Center.

B. Out-of-Network
We do not cover Urgent Care from Non-Participating Urgent Care Centers or Physicians in Our Service Area.

If Urgent Care results in an Emergency admission please follow the instructions for Emergency Hospital admissions described above.

6.4 OUTPATIENT AND PROFESSIONAL SERVICES
(For other than Mental Health and Substance Use)

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

6.4.1 Advanced Imaging Services
We Cover PET scans, MRI, nuclear medicine, and CAT scans.

6.4.2 Allergy Testing and Treatment
We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

6.4.3 Ambulatory Surgery Center
We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the Center the day the surgery is performed.

6.4.4 Chemotherapy
We Cover Chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Section of this Contract.

6.4.5 Chiropractic Services
We Cover chiropractic care when performed by a Doctor of Chiropractic ("Chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or sublaxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this Contract.

6.4.6 Dialysis
We Cover dialysis treatments of an Acute or chronic kidney ailment.

We also Cover dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than ten dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

6.4.7 Habilitation Services
We Cover Habilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition, per lifetime.

6.4.8 Home Health Care
We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes (i) part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational, or speech therapy provided by the Home Health Agency, and (iv) medical supplies, drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to 40 visits per Plan year. Each visit by a member of the Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is one visit. Please note: Any rehabilitation services received under this benefit will not reduce the amount of services available under "Rehabilitation and Habilitation Services".

6.4.9 Interruption of Pregnancy
We Cover therapeutic abortions. We also Cover non-therapeutic abortions in cases of rape, incest, or fetal malformation.

6.4.10 Infertility Treatment
We Cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease, or dysfunction. Such Coverage is available as follows:

- Basic Infertility Services. Basic Infertility Services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, endometrial biopsy, pelvic ultra sound, hysterosalpingogram, sono-hystogram, testis biopsy, blood tests, and medically appropriate treatment of ovulatory dysfunction. Additional tests may be Covered if the tests are determined to be Medically Necessary.
- Comprehensive Infertility Services . If the Basic Services do not result in increased fertility, We Cover Comprehensive Infertility Services. These services include: ovulation induction and monitoring; pelvic ultra sound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.
- Exclusions and Limitations
    a. In vitro, GIFT and ZIFT procedures.
    b. Cost for an ovum donor or donor sperm.
    c. Sperm storage costs.
    d. Cryopreservation and storage of embryos.
    e. Ovulation predictor kits.
    f. Reversal of tubal ligations. Reversal of vasectomies.
    g. All costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers).
    h. Sex change procedures.
    i. Cloning.
    j. Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.
    k. All services 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.

6.4.11 Infusion Therapy
We Cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected into the muscles are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count towards Your home health care visit limit.

6.4.12 Laboratory Procedures, Diagnostic Testing and Radiology Services
We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

6.4.13 Maternity and Newborn Care
We Cover services for maternity care provided by a Physician or nurse midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a nurse midwife to be Covered, the nurse midwife must be licensed pursuant to Article 140 of the Education Law, practicing consistent with Section 6951 of the Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the Public Health Law. We will not pay for duplicative routine services provided by both a nurse midwife and a Physician. See Section VI of the Certificate for coverage of inpatient maternity care.

We Cover the cost of renting one breast pump per pregnancy for the duration of breast feeding.

6.4.14 Medications for Use in the Office: We Cover medications and injectables (excluding self-injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes.

6.4.15 Office Visits
We Cover office visits for the diagnosis and treatment of injury, disease, and medical conditions. Office visits may include house calls.

6.4.16 Outpatient Hospital Services
We Cover Hospital services and supplies as described in the Inpatient Hospital Section that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation. **Please remember**, unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests.

6.4.17 Preadmission Testing
We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient facilities prior to a scheduled surgery in the same Hospital provided that: the tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed; reservations for a Hospital bed and operating room were made prior to the performance of the tests; surgery takes place within seven days of the tests; and the patient is physically present at the Hospital for the tests.

6.4.18 Rehabilitation Services
We Cover Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition, per lifetime. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- It is ordered by a Physician; and
- You have been Hospitalized or have undergone surgery for such illness or injury.

Covered speech, physical and occupational therapy services must begin within six months of the latter to occur:

- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

In no event will the therapy continue beyond 365 days after such event.

6.4.19 Second Opinions

- Second Cancer Opinion. We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-participating Provider on an In-Network basis when Your attending Physician provides a written Referral to a Non-Participating Specialist.
- Second Surgical Opinion. We Cover a second surgical opinion by a qualified Physician on the need for surgery.
- Required Second Surgical Opinion. We may require a second opinion before We Preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
    a. The second opinion must be given by a board certified Specialist who personally examines You.
    b. If the first and second opinions do not agree You may obtain a third opinion.
    c. The second and third surgical opinion consultants may not perform the surgery on You.
- Second Opinions in other Cases. There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will Preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

6.4.20 Surgical Services

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

Sometimes two or more surgical procedures can be performed during the same operation.

- Through the Same Incision. If Covered multiple surgical procedures are through the same incision, We will pay for the procedure with the highest Allowed Amount.

- Through Different Incisions. If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
    a. For the procedure with the highest Allowed Amount; and
    b. 50% of the amount We would otherwise pay for the other procedures.

6.4.21 Oral Surgery

We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.

- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

6.4.22 Reconstructive Breast Surgery
We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. Implanted breast prostheses following a mastectomy or partial mastectomy are also Covered.

6.4.23 Other Reconstructive and Corrective Surgery
We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when:
- It is performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect; or
- It is incidental to surgery or follows surgery that was necessitated by trauma, infection, or disease of the involved part; or
- It is otherwise Medically Necessary.

6.4.24 Transplants
We Cover only those transplants determined to be nonexperimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. The medical expenses of a non-Member acting as a donor for You are not Covered if the non-Member's expenses will be Covered under another health plan or program.
We do not Cover travel expenses, lodging, meals, or other accommodations for donors or guests. We do not Cover donor fees in connection with organ transplant surgery. We do not Cover routine harvesting and storage of stem cells from newborn cord blood.

6.5 ADDITIONAL BENEFITS, EQUIPMENT, AND DEVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

6.5.1 Autism Spectrum Disorder
We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "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).

- **Screening and Diagnosis:** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

- **Assistive Communication Devices**: We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We will not Cover items, such as, but not limited to, laptops, desktop, or tablet computers. We Cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

  Repair, replacement fitting, and adjustments of such devices are Covered when made necessary by normal wear and tear or significant change in Your physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not Covered.However, We will Cover one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We will not provide Coverage for delivery or service charges or for routine maintenance.

- **Behavioral Health Treatment:** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis 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.

  Our Coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.

- **Psychiatric and Psychological Care**: We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.

- **Therapeutic Care**: We Cover 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 this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

- **Pharmacy Care**: We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Certificate.

We will not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized service plan pursuant to regulations of the Office for Persons With Developmental Disabilities shall not affect coverage under the Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Deductible, Copayment, or Coinsurance provisions under this Certificate for similar services. For example, any Deductible, Copayment, or Coinsurance that applies to physical therapy visits generally will also apply to physical therapy services Covered under this benefit; and any Deductible, Copayment, or Coinsurance for Prescription Drugs generally will also apply to Prescription Drugs Covered under this benefit. Any Deductible, Copayment, or Coinsurance that applies to office visits will apply to assistive communication devices Covered under this paragraph.

Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

6.5.2 Diabetic Equipment, Supplies, and Self-Management Education
We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the Education Law as described below:

6.5.3 Supplies
We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other provider legally authorized to prescribe:

- Acetone Reagent Strips
- Acetone Reagent Tablets
- Alcohol or Peroxide by the pint
- Alcohol Wipes
- All insulin preparations
- Automatic Blood Lance Kit
- Blood Glucose Kit
- Blood Glucose Strips (Test or Reagent)
- Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the Pump
- Glucose Acetone Reagent Strips
- Glucose Reagent Strips

- Glucose Reagent Tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin Cartridge Delivery
- Insulin infusion devices
- Insulin Pump
- Lancets
- Oral agents such as glucose tablets and gels
- Glucagon for injection to increase blood glucose concentration
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

6.5.4 Self-Management Education
Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care provider authorized to prescribe under Title 8 of the Education Law, or their staff during an office visit;
- Upon the referral of Your Physician or other health care provider authorized to prescribe under Title 8 of the Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

6.5.5 Limitations
The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness.

6.5.6 Durable Medical Equipment and Braces
We Cover the rental or purchase of durable medical equipment and braces.

6.5.7 Durable Medical Equipment
Durable Medical Equipment is equipment which is:

- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- is appropriate for use in the home.

Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. We do not Cover the cost of repairs or replacement that are the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment.

Customized or motorized equipment, or equipment designed for Your comfort or convenience (such as pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment) are not Covered as they do not

meet the definition of durable medical equipment.

6.5.8 Braces
We Cover braces that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease, or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repairs or replacement that are the result of misuse or abuse by You.

6.5.9 Hearing Aids
We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years.

Bone anchored hearing aids are Covered only if You have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

If You meet the criteria for a bone anchored hearing aid, Coverage is provided for one hearing aid per ear during the entire period of time that You are enrolled under this Certificate. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions.

6.5.10 Hospice
Hospice Care is available if Your primary attending Physician has certified that You have six months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

6.5.11 Medical Supplies
We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. Please see the "Diabetic Supplies, Education, and Self-Management" Section of this Certificate for a description of diabetic supply Coverage.

6.5.12 Prosthetics:

6.5.12a External Prosthetic Devices
We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently

replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials. Dentures or other devices used in connection with the teeth are not Covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. Eyeglasses and contact lenses are not Covered under this Section of the Certificate and are only covered under the pediatric vision benefit in Section VI of this Certificate. We do not Cover orthotics.

For adults, We Cover the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown.

Coverage is for standard equipment only. We do not otherwise Cover the cost of repairs or replacement.

We also Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

6.5.12b Internal Prosthetic Devices
We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.

6.6 INPATIENT SERVICES
(For other than Mental Health and Substance Use)

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

6.6.1 Hospital Services
We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special, and critical nursing care;
- Meals and special diets;
- The use of operating, recovery, and cystoscopic rooms and equipment;
- The use of intensive care, special care, or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals, and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and plaster casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy, and cardiac rehabilitation;
- Short-term physical, speech, and occupational therapy; and

- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.

6.6.2 Observation Services
We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. The services include use of a bed and periodic monitoring by nursing or other licensed staff.

6.6.3 Inpatient Medical Services
We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

6.6.4 Inpatient Stay for Maternity Care
We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits that apply to home care benefits.

6.6.5 Inpatient Stay for Mastectomy Care
We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy, or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period time determined to be medically appropriate by You and Your attending Physician.

6.6.6 Autologous Blood Banking Services
We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

6.6.7 Rehabilitation Services
We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy for up to one consecutive 60-day period, per condition, per lifetime. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

a. such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
b. it is ordered by a Physician; and
c. You have been Hospitalized or have undergone surgery for such illness or injury.

Covered Services must begin within six months of the latter to occur:

a. the date of the injury or illness that caused the need for the therapy;
b. the date You are discharged from a Hospital where surgical treatment was rendered; or
c. the date outpatient surgical care is rendered.

6.6.8 Skilled Nursing Facility
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the "Exclusions and Limitations" Section of this Certificate.) An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to 200 days, per Plan Year, for non-custodial care.

6.6.9 End of Life Care
If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

a. We will reimburse a rate that has been negotiated between Us and the Provider.
b. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care service rates.

c. Or if it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare rates.

6.6.10 Limitations/Terms of Coverage:

a. When You are receiving inpatient care in a Hospital or other Facility as described above, We will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room.

b. We do not Cover radio, telephone, and television expenses, or beauty or barber services.

c. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for you to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

6.7 MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

6.7.1 Mental Health Care Services

A. Inpatient Services
We Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous, and emotional disorders comparable to other similar Hospital, medical, and surgical coverage provided under this Certificate. However, Coverage for inpatient services for mental health care is limited to Facilities as defined by New York Mental Hygiene Law § 1.03 subdivision 10.

B. Outpatient Services
We Cover outpatient mental health care services, including but not limited to partial Hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous, and emotional disorders. Such Coverage is limited to Facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a Facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of NY Ins. Law §§ 3221(l)(4)(D), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.

C. Limitations/Terms of Coverage:

a) We will not Cover 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.

b) We will not Cover 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 the Office of Children and Family Services.

c) We will not Cover services solely because they are ordered by a court.

6.7.2 Substance Use Services

A. Inpatient Services
We Cover inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes Coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

B. Outpatient Services
We Cover outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such Coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by Physicians who have been granted a waiver pursuant to the Drug Addiction and 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; and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.

We also Cover up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use, and/or dependence. Our

payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

6.8 PRESCRIPTION DRUG COVERAGE

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

6.8.1 Covered Outpatient Prescription Drugs

We Cover Medically Necessary Outpatient Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Non-prescription enteral formulas for home use for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen 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, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the "Infertility" Section of this Certificate.
- 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 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.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Prescription Drugs for smoking cessation. .

You may request a copy of Our drug formulary. Our drug formulary is also available on Our website at

http://newyork.healthrepublic.us/formulary. You may also inquire if a specific drug is Covered under this Certificate by contacting us at the number on Your ID card.

6.8.2. Refills We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order or Designated pharmacy as ordered by an authorized Provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. 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 in the Schedule of Benefits in Section XIV of this Certificate.

6.8.3 Benefit and Payment Information

A. **Cost-Sharing Expenses:** You are responsible for paying the costs outlined in the Schedule of Benefits in Section XIV of this Certificate when Covered Prescription Drugs are obtained from a retail or mail order or Designated pharmacy.

   You have a three tier plan design, which means that Your Out-of-Pocket Expenses will generally be lowest for Prescription Drugs on Tier 1 and highest for Prescription Drugs on Tier 3. Your Out-of-Pocket Expense for Prescription Drugs on Tier 2 will generally be more than for Tier 1 but less than Tier 3.

   You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

B. **Participating Pharmacies:** For Prescription Drugs purchased at a retail or mail order or designated Participating Pharmacy, You are responsible for paying the lower of:

   - The applicable Cost-Sharing; or
   - The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required In-Network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at 888-990-5702 or visit our website at http://newyork.healthrepublic.us to request approval.

C. **Non-Participating Pharmacies:** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

D. **Designated Pharmacies:** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

   Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused, or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient

supports.

If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, You will not have Coverage for that Prescription Drug.

Following are the therapeutic classes of Prescription Drugs that are included in this program:

- Age related macular edema
- Anemia, neutropenia, thrombocytopenia
- Crohn's Disease
- Cystic Fibrosis
- Cytomegalovirus
- Endocrine disorders/Neurologic disorders such as infantile spasms
- Enzyme Deficiencies/Liposomal Storage Disorders
- Gaucher's Disease
- Growth Hormone
- Hemophilia
- Hepatitis B, Hepatitis C
- Hereditary Angioedema
- HIV/AIDS
- Immune Deficiency
- Immune Modulator
- Infertility
- Iron Overload
- Iron Toxicity
- Multiple Sclerosis
- Oral Oncology
- Osteoarthritis
- Osteoporosis
- Parkinson's Disease
- Pulmonary Arterial Hypertension
- Respiratory Condition
- Rheumatologic and related conditions (Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Juvenile Rheumatoid Arthritis, Psoriasis)
- Transplant
- RSV Prevention

E. **Mail Order:** Certain Prescription Drugs may be ordered through Our mail order supplier and You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   To maximize Your benefit, ask Your Physician to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order supplier regardless of the number of days supply written on the Prescription Order or Refill.

   Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website http://newyork.healthrepublic.us/formulary or by calling the Customer Service number on Your ID card.

F. **Tier Status:** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six times per Plan Year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website http://newyork.healthrepublic.us or by calling the Customer Service number on Your ID card.

G. **When a Brand-Name Drug Becomes Available As a Generic:** When a Brand-Name Drug becomes available as a Generic, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded due to a generic becoming available You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in Section IX of the Certificate.

H. **Supply Limits:** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one Cost-Sharing amount for up to a 30-day supply. However, for maintenance drugs we will pay for up to a 90-day supply of a drug purchased at a retail pharmacy. You are responsible for one Cost-Sharing amount for a 90-day supply at a retail pharmacy.

   Benefits will be provided for drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one Cost-Share amount for a 30-day supply up to a maximum of two and a half Cost-Share amounts for a 90-day supply. We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with Us in which it agrees to be bound by the same terms and conditions as a Participating mail order pharmacy.

   Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website http://newyork.healthrepublic.us or by calling Customer Service at the telephone number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to Section IX of the Certificate.

I. **Cost-Sharing for Orally-Administered Anti-cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the Schedule of Benefits in Section XIV of this Certificate or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under Section VI of this Certificate.

6.8.4 Medical Management

This Certificate includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

A. **Preauthorization:** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug. Should You choose to purchase the Prescription Drug without obtaining Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement.

   For a list of Prescription Drugs that need Preauthorization, please visit our website http://newyork.healthrepublic.us/formulary or call the Customer Service number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or of any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification. Including a Prescription Drug or related item on the list does not promise coverage under Your Plan. Your Provider may check with Us to find out which Prescription Drugs are Covered.

B. **Step Therapy**: Step therapy is a process in which You may need to use one type of Prescription Drug before We will Cover another as Medically Necessary. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. The Prescription Drugs that require preauthorization under the Step Therapy Program are also included on the preauthorization drug list.

C. **Therapeutic Substitution:** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website at http://newyork.healthrepublic.us or call the Customer Service at the phone number on Your ID Card.

6.8.5 Limitations/Terms of Coverage

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

B. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You don't make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

C. 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 pharmacy that is approved for compounding. All compounded Prescription Drugs require You to obtain Preauthorization.

D. 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.

E. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies are not Covered under this Section but are Covered under other Sections of this Certificate

F. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under Section VI of this Certificate.

G. We do not Cover drugs that do not by law require a prescription, except as otherwise provided in this Certificate.

H. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

I. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

J. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

K. Your benefit for insulin, diabetic Prescription Drugs, supplies, and equipment is not provided under this Section of the Certificate and is Covered under Section VI of the Certificate.

L. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in Section IX of this Certificate.

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

N. We do not Cover nutritional supplements (formulas), non-prescription enteral formulas, and modified food solid products except as described under the "Covered Outpatient Prescription Drug" Section of this Certificate.

6.8.6 General Conditions

A. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

B. **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, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage. We may, from time-to-time, also enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug

manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member'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, 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 Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

6.9 DEFINITIONS

Terms used is this Section are defined as follows. (Other defined terms can be found in the "Definitions" Section of this Certificate).

Brand-Name Drug: A Prescription Drug that (1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as a "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as Brand-Name Drug by Us.

Designated Pharmacy: A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

Formulary: The list that identifies those Prescription Drugs for which Coverage may be available under this Certificate.This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per PlanYear). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website http://newyork.healthrepublic.us/formulary or by calling the Customer Service number on Your ID card.

Generic Drug: A Prescription Drug that (1) is chemically equivalent to a Brand-Name Drug; or (2) that We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as a "generic" by the manufacturer, pharmacy, or Your Physician may not be classified as a Generic Drug by Us.

Non-Participating Pharmacy: A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

Participating Pharmacy: A pharmacy that has:

- entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
- agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
- has been designated by Us as a Participating Pharmacy.

A Participating Pharmacy can be either a retail or mail-order pharmacy.

Prescription Drug: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Prescription Drug Cost: The rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Plan includes Coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

Prescription Order or Refill: The directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Usual and Customary Charge: The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by Section 6826-a of the Education Law.

6.10 WELLNESS

Exercise Facility Reimbursement

We will partially reimburse the Subscriber and the Subscriber's Covered Spouse for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities that We have an agreement with and which maintain equipment and programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual work-out visits. We will not provide reimbursement for equipment, clothing, vitamins, or other services that may be offered by the facility (massages, yoga, etc.).

In order to be eligible for reimbursement, You must:

- be an active member of the exercise facility, and
- complete 50 visits in a six-month period.

In order to obtain reimbursement, at the end of the six-month period You must submit:

- a completed Reimbursement Form. Each time You visit the facility, a facility representative must sign and date the Reimbursement Form.
- a copy of Your current facility bill which shows the fee paid for Your membership.

Once We receive the completed reimbursement form and the bill, You will be reimbursed the lesser of $200 for the Subscriber and $100 for the Subscriber's Spouse or the actual cost of the membership per six-month period.

6.11 PEDIATRIC VISION CARE

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

6.11.1 Pediatric Vision Care

We Cover emergency, preventive and routine vision care for Children up to age 19.

6.11.2 Vision Examinations

We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover one vision examination in any twelve (12) month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The

vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

6.11.3 Prescribed Lenses & Frames

We Cover standard prescription lenses or contact lenses once in any twelve (12) month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames adequate to hold lenses once in any twelve (12) month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation.

SECTION VII – EXCLUSIONS AND LIMITATIONS

No Coverage is available under this Certificate for the following:

7.1 Aviation
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

7.2 Convalescent and Custodial Care
We do not Cover services related to rest cures, custodial care, and transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting, and other such related activities. Custodial care does not include Covered services determined to be Medically Necessary.

7.3 Cosmetic Services
We do not Cover cosmetic services, Prescription Drugs, or surgery except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (for example, certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in Section IX of this Certificate.

7.4 Coverage Outside of the United States, Canada or Mexico
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services to treat Your Emergency Condition.

7.5 Dental Services
We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as specifically stated in the "Oral Surgery" Section of this Certificate.

7.6 Experimental or Investigational Treatment
We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Certificate for non-investigational treatments. See Section IX of this Certificate for a further explanation of Your Appeal rights.

7.7 Felony Participation
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot, or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence.

7.8 Foot Care
We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, except as specifically listed in this Certificate. For foot care related to diabetes, see Section VI of this Certificate.

7.9 Government Facility
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law, unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

7.10 Medically Necessary
In general, We will not Cover any health care service, procedure, treatment, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the procedure, treatment, service, or Prescription Drug for which Coverage has been denied, to the extent that such procedure, treatment, service, or Prescription Drug is otherwise Covered under the terms of this Certificate.

7.11 Medicare or Other Governmental Program
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

7.12 Military Service
We do not Cover an illness, treatment, or medical condition due to service in the Armed Forces or auxiliary units.

7.13 No-Fault Automobile Insurance
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. 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 .

7.14 Services Separately Billed by Hospital Employees
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories, or other institutions.

7.15 Services Provided by a Family Member
We do not Cover services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your spouse.

7.16 Services With No Charge
We do not Cover services for which no charge is normally made.

7.17 Services not Listed
We do not Cover services that are not listed in this Certificate as being Covered.

7.18 Vision Services
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in Section VI of this Certificate.

7.19 Workers' Compensation
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability, or occupational disease law.

7.20 War
We will not Cover an illness, treatment, or medical condition due to war, declared or undeclared.

SECTION VIII - CLAIM DETERMINATIONS

8.1 Claims
A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider you will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

8.2 Notice of Claim
Claims for services 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, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the Provider making the charge, 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. Claim forms are available from Us by calling the number on your ID card. Completed claim forms should be sent to the address in Section II of this Certificate or on Your ID card.

8.3 Timeframe for Filing Claims
Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 day period, You must submit it as soon as reasonably possible.

8.4 Claims for Prohibited Referrals
We are not required to pay any claim, bill, or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services, or x-ray or imaging services furnished pursuant to a referral prohibited by N.Y. Public Health Law § 238-a(1).

8.5 Claim Determinations
Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies to Referrals and contractual benefit denials. If You disagree with Our claim determination you may submit a Grievance pursuant to Section IX of this Certificate.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see Section IX of this Certificate.

A pre-service claim is a request that a service or treatment be approved before it has been received. A post-service claim is a request for a service or treatment that You have already received.

8.6 Pre-Service Claim Determinations
If We have all the information necessary to make a determination regarding a pre-service claim (for example a Referral or a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15

calendar days of the end of the 45 day period.

8.7 Urgent Pre-service Reviews
With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period. Written notice will follow within three calendar days of the decision.

8.8 Post-service Claim Determinations
If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

SECTION IX – GRIEVANCE, UTILIZATION REVIEW, & EXTERNAL APPEALS

9.1 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.

9.1.1 Filing a Grievance

You can contact Us by phone at 888-990-5702, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a referral or a Covered benefit determination. 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.

9.1.2 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 are not in relation to a claim or request for service.)	In writing, within 30 calendar days of receipt of Your Grievance

9.1.3 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. However, Urgent Appeals may be filed by phone. 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

If You need assistance filing a Grievance or Appeal You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010
Or call toll free: 1-888-614-5400
OR 888-990-5702
Or e-mail cha@cssny.org

9.2 UTILIZATION REVIEW

9.2.1 Utilization Review
We review 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 performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card.

All determinations that services are not Medically Necessary will be made by licensed Physicians or by licensed, certified, registered, or credentialed health care professionals who are in the same profession and same or similar specialty as the health care Provider who typically manages Your medical condition or disease or provides the health care service under review. 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 upon request. For more information, You can contact Us.

9.2.2 Preauthorization Reviews
If We have all the information necessary to make a determination regarding a Preauthorization 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 3 business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, 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 Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

9.2.3 Urgent Preauthorization Reviews
With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will follow within one calendar day of the decision. 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.

After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

9.2.4 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 necessary information. If We need additional information, We will request it within one business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a

determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business of Our receipt of the information or, if We do not receive the information, within one 1 business day of the end of the 45-day time period.

9.2.5 Urgent Concurrent Reviews
For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one business day of receipt of the request for coverage if all necessary information was included or three calendar days from the verbal notification if all necessary information was not included. If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, the Urgent Preauthorization Review timeframes apply.

9.2.6 Retrospective Reviews
If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. 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 in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

Once We have all the information to make a decision, Our failure to make a Utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

9.2.7 Retrospective Review of Preauthorized Services
We may only reverse a preauthorized treatment, service, or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service, or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria, or procedures as used during the Preauthorization review.

9.2.8 Reconsideration
If We did not attempt to consult with Your Provider before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

9.2.9 Utilization Review Internal Appeals
You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. You are not eligible for a

Utilization Review Appeal if the service you request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating your condition. (Such an Appeal will be treated as a Grievance.) For a Utilization Review Appeal of denial of an Out-of-Network health service, You, or Your designee, must submit:

- A statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested Out-of-Network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and

- Two documents from the available medical and scientific evidence that the Out-of-Network service:

  (a) Is likely to be more clinically beneficial to You than the alternate In-Network service; and

  (b) that the adverse risk of the Out-of-Network service would likely not be substantially increased over the In-Network health service.

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 a Physician or a Health Care Professional 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.

9.2.10 First Level Appeal

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate, Your Provider, within two business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate, Your Provider, within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

9.2.11 Expedited Appeals

Appeals of reviews of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, 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 from receipt of the Appeal or two business days of receipt of the information necessary to conduct the Appeal.

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 Appeal within 60 calendar days of receipt of the necessary

information for a standard Appeal or within two business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

9.2.12 Second Level Appeal

If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external Appeal. **The four month timeframe for filing an external Appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external Appeal.**

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level 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.

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate, Your Provider, within two business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
OR 888-990-5702
Or e-mail: cha@cssny.org

9.3 EXTERNAL APPEAL

I. YOUR RIGHT TO AN EXTERNAL APPEAL

In some cases, You have a right to an external appeal of a denial of coverage. Specifically, if We have denied coverage on the basis that a service does not meet Our requirements for Medical Necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Certificate, and

- In general, You must have received a final adverse determination through the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:

    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
    - We fail to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

II. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY

If We have denied coverage on the basis that the service does not meet Our requirements for Medical Necessity, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in I, above.

III. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL

If We have denied coverage on the basis that the service is an experimental or investigational treatment, You must satisfy the two requirements for an external appeal in **I**, above, and Your attending Physician must certify that: (1) Your condition or disease is one for which standard health services are ineffective or medically inappropriate; **or** (2) one for which there does not exist a more beneficial standard service or procedure covered by Us; **or** (3) one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one of the following:

- A service, procedure, or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or

- A clinical trial for which You are eligible (only certain clinical trials can be considered); or

- A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this Section, Your attending Physician must be a licensed, board-certified, or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

IV. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS OUT-OF-NETWORK

If We have denied coverage of an Out-of-Network treatment because it is not materially different than the health service available In-Network, You may appeal to an External Appeal Agent if You meet the two requirements for an external appeal in I above, and You have requested preauthorization for the Out-of-Network treatment.

In addition, Your attending Physician must certify that the Out-of-Network service is materially different from the alternate recommended In-Network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate In-Network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate In-Network health service.

For purposes of this Section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

You do not have a right to an external appeal for a denial of a Referral to an Out-of-Network provider on the basis that a health care provider is available In-Network to provide the particular health service requested by You.

V. THE EXTERNAL APPEAL PROCESS

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited appeal (described below), We do not have a right to reconsider Our decision.

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

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health, or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify You and Us by telephone or

facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

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

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

We will charge You a fee of $25 for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

VI. YOUR RESPONSIBILITIES

It is Your RESPONSIBILITY to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION X – COORDINATION OF BENEFITS

This Section applies when you also have group health coverage with another plan. When You receive a Covered service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This prevents duplicate payments and overpayments.

10.1 Definitions

Allowable Expense is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

Plan is other group health coverage with which We will coordinate benefits. The term **plan** includes:

A. Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

B. Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

C. Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

Primary plan is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: (1) the plan has no order of benefits rules or its rules differ from those required by regulation; or (2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

Secondary plan is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

10.2 Rules to Determine Order of Payment

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

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

B. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

C. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result

the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

D. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

   a. The plan of the parent who has custody will be primary;

   b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.

   c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

E. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

F. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

10.3 Effects of Coordination
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

10.4 Right to Receive and Release Necessary Information
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

10.5 Our Right to Recover Overpayment
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

10.6 Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans
We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

A. If this Certificate is primary, as defined in this Section, We will pay benefits first.

B. If this Certificate is secondary, as defined in this Section, We will pay only the amount We would pay as the secondary insurer.

C. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

SECTION XI – TERMINATION OF COVERAGE

Coverage under this Certificate will automatically be terminated on the first of the following to apply. In all cases of termination, unless otherwise noted below, the Exchange will provide at least 30 days prior, written notice to the Group.

1. The Group, and/or Subscriber, has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.

2. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Upon the Subscriber's death, coverage will terminate unless You have coverage for Dependents. If You have coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the end of the month in which the Child turns 26 years of age. For all other Dependents, the date the Dependent ceases to be eligible.

6. The end of the month during which the Subscriber provides written notice to the Exchange requesting termination of coverage, or on such later date requested for such termination by the notice.

7. If a Subscriber has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by the Exchange to the Subscriber. However, if a Subscriber makes an intentional misrepresentation of material fact in writing on his/her enrollment application we will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to the date of Your enrollment under the Certificate.

8. The date that the Group Contract is terminated. If We terminate and/or decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days prior written notice.

9. If We elect to terminate or cease offering all hospital, surgical, and medical expense coverage in the small group market, in this state, We will provide written notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.

10. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

11. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage.

12. The date there is no longer any enrollee who lives, resides, or works in Our Service Area.

No termination of coverage shall prejudice the right to a claim for benefits which arose prior to such termination.

See Section XII of this Certificate for Your right to continuation of this coverage and Section XII of this Certificate for Your right to conversion to an individual Contract.

SECTION XII – WHAT HAPPENS IF YOU LOSE COVERAGE

12.1 EXTENSION OF BENEFITS

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Group Contract terminates, or on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability.

For purposes of this Section, total disability means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

12.1.2 When You May Continue Benefits

When Your coverage under this Certificate ends, We will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within 31 days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to 12 months from the date Your coverage ends for Covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

12.1.3 Termination of Extension of Benefits

Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- 12 months from the date extended benefits began (if Your benefits are extended based on termination of employment);
- With respect to the 12 month extension of coverage, the date You become eligible for benefits under any group Contract providing medical benefits.

12.1.4 Limits on Extended Benefits

We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Certificate ends;
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended

12.2 CONTINUATION OF COVERAGE

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse, and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

A. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g. a reduction in the number of hours of employment) You may continue coverage. Coverage may be continued for You, Your Spouse, and any of Your Covered Children.

B. If You are a Covered Spouse, You may continue coverage if Your coverage ends due to:
   a. Voluntary or involuntary termination of the Covered employee's employment;
   b. Reduction in the hours worked by the Covered employee or other change in the employee's class;
   c. Divorce or legal separation of the Covered employee;
   d. Death of the Covered employee; or
   e. The Covered employee becoming entitled to Medicare.

C. If You are a Covered Child, You may continue coverage if Your coverage ends due to:
   a. Voluntary or involuntary termination of the Covered employee's employment;
   b. Reduction in the hours worked by the Covered employee or other change in the employee's class;
   c. Loss of Covered Child status under the plan rules;
   d. Death of the Covered employee; or
   e. The Covered employee becoming entitled to Medicare.

D. If You want to continue coverage You must request continuation from Your employer in writing and make the first Premium payment within the 60-day period following the later of:
   a. The date coverage would otherwise terminate; or
   b. The date You are sent notice by first class mail of the right of continuation by the Group contractholder.

The contractholder can charge up to 102% of the Group Premium for continued coverage.

E. Continued coverage under this Section will terminate at the earliest of the following:
   a. The date 36 months after Your coverage would have terminated because of termination of employment;
   b. If You are a Covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the employee, divorce or legal separation, the employee's eligibility for Medicare, or the failure to qualify under the definition of "Children";
   c. The date You become Covered by an insured or uninsured arrangement that provides group hospital, surgical, or medical coverage;
   d. The date You become entitled to Medicare;
   e. The date to which Premiums are paid if You fail to make a timely payment; or
   f. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See Section XII of the Certificate.

12.2.1 Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during

active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and

2. You serve no more than four years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group contractholder the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

A. Your coverage under this Certificate may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your Covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.

B. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one year.

12.2.2 Age 29 Dependent Coverage Extensions Young Adult Option

Your Child may be eligible to purchase his or her own individual coverage under Your Group's; Contract through the age of 29 if he or she 1) is under the age of 30; 2) is not married; 3) is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured; 4) lives, works or resides in New York State or Our Service Area; and 5) is not covered by Medicare. The Child may purchase coverage even if he or she is not financially Dependent on his or her parent(s) and does not need to live with his or her parent(s).
Your Child may elect this coverage:

A. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
B. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the Group contractholder or Group contractholder's designee receives notice and We receive Premium payment;
C. During an annual 30-day open enrollment period, in which case coverage will be prospective and will start within 30 days of when the Group contractholder or Group contractholder's designee receives notice of election and We receive Premium payment.

You or Your Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Certificate. Your Child's children are not eligible for coverage under this option.

12.3 CONVERSION RIGHT TO NEW CONTRACT AFTER TERMINATION

You have the right to convert to a new Contract if coverage under this Certificate terminates under the circumstances described below.

A. **Termination of the Group Contract.** If the Group Contract between Us and the Group Contractholder is terminated as set forth in Section XI of this Certificate, and the Group Contractholder has not replaced the coverage for the Group with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Contract as direct payment members.

B. **If You Are No Longer Covered in a Group.** If Your coverage terminates under Section XI of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Contract as a direct payment member.

C. **On the Death of the Subscriber.** If coverage terminates under Section XI of this Certificate because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

D. **Termination of Your Marriage.** If a Spouse's coverage terminates under Section XI of this Certificate because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.

E. **Termination of Coverage of a Child.** If a Child's coverage terminates under Section XI of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.

F. **Termination of Your Temporary Continuation of Coverage.** If coverage terminates under Section XI of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Contract as a direct payment member.

G. **Termination of Your Young Adult Coverage.** If a Child's young adult coverage terminates under Section XI of this Certificate, the Child is entitled to purchase a new Contract as a direct payment member.

12.3.1 When to Apply for the New Contract

If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 60 days after termination of coverage under this Certificate. You must also pay the first Premium of the new Contract at the time You apply for coverage.

12.3.2 The New Contract

We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold, or platinum) that covers all benefits required by state and federal law. You may choose among any of the four

Policies offered by Us. However, the coverage may not be the same as Your current coverage. However, if We determine that You do not reside in New York State, We may issue You or Your family members coverage on a form that we use for conversion in that state.

12.3.3 When Conversion Is Not Available

We will not issue You an individual direct payment Contract if the issuance of the new Contract will result in overinsurance or duplication of benefits according to the standards We have on file with the Superintendent of the New York State Department of Financial Services.

SECTION XIII - GENERAL PROVISIONS

13.1 Agreements between Us 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. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

13.2 Assignment

You cannot assign any benefits or monies due under 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. However, You may request Us to make payment for services directly to Your Provider instead of You.

13.3 Changes in This Certificate

We may unilaterally change this Certificate upon renewal, if We give the Group Contractholder 30 days' prior written notice.

13.4 Choice of Law

This Certificate shall be governed by the laws of the State of New York.

13.5 Clerical Error

Clerical error, whether by the Group Contractholder or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

13.6 Continuation of Benefit Limitations

Some of the benefits under this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the Year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when you were a covered family member will be applied toward your new status as a Subscriber.

13.7 Enrollment ERISA

The Group Contractholder 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 Contractholder will provide Us with this information upon request.

The Group Contractholder 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 Contractholder, or a third party appointed by the Group Contractholder. We are not the ERISA plan administrator.

13.8 Entire Agreement

This Certificate, including any endorsements, riders, and the attached applications, if any, constitutes the entire Certificate.

13.9 Furnishing Information and Audit
The Group Contractholder 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 Contractholder 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 Contractholder's New York office.

13.10 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 Your Premiums must be paid in full at the time that the services are sought to be received.

13.11 Incontestability
No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

13.12 Independent Contractors
Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your Covered Spouse, or Children while receiving care from any Participating Provider or in any Participating Provider's facility.

13.13 Material Accessibility
We will give the Group Contractholder, and the Group Contractholder will give You, identification cards, Certificates, riders, and other necessary materials.

13.14 More Information about Your Health Plan
You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information.

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device, or treatment in clinical trials.
- Provider affiliations with Participating Hospitals.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider

regarding a specific disease, course of treatment, or utilization review guidelines.

13.15 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 Contractholder. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: Health Republic Insurance of New York, 30 Broad Street, 34th Floor, New York NY 10004. You may also upload it via the secured member section of our website at http://newyork.healthrepublic.us.

13.16 Premium Refund
We will give any refund of Premiums, if due, to the Group Contractholder.

13.17 Recovery of Overpayments
On occasion, a payment will be made to You 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. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

13.18 Renewal Date
The renewal date for the Certificate is the anniversary of the effective date of the Group Contract each Year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by Us or the Group Contractholder as permitted by the Contract, or by You upon 30 days' prior written notice to the Group Contractholder.

13.19 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 surgery was Medically Necessary to treat Your illness or injury; 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.

13.20 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 owe to Us. Except as otherwise required by law, 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.

13.21 Severability
The unenforceability or invalidity of any provision of the Certificate shall not affect the validity and enforceability of the remainder of the Certificate.

13.22 Significant Change in Circumstances
If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to

provide or arrange for Covered Services if such failure or delay is caused by such an event.

13.23 Subrogation and Reimbursement
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness or other condition and We have provided benefits related to that injury, illness, or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Certificate. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if you or anyone on your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict, or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under New York General Obligations Law 5-335, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by You for which we have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

13.24 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 two 2 years from the date the claim was required to be filed.

13.25 Translation Services
Translation services are available under this Certificate for non-English speaking Members. Please contact us at 888-990-5702 to access these services.

13.26 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.

13.27 Waiver
The waiver by any party of any breach of any provision of the Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

13.28 Who May Change This Certificate
The Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer (CEO) or a person designated by the CEO. 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 CEO or person

designated by the CEO.

13.29 Who Receives Payment under This Certificate
Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.

13.30 Workers' Compensation Not Affected
The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

13.31 Your Medical Records and Reports
In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, 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. By accepting coverage under this Certificate, You automatically give Us or our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to 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;

- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and

- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your 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.

Exhibit B

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*Admitted CT Only
~Admitted NY Only
#Admitted NY & CT
+Admitted NY & NJ

January 20, 2017

Eliot J. Kirshnitz, Esq.
Special Counsel, Legal Division
New York Liquidation Bureau
110 William Street, New York, NY 10038

Re: In the Matter of Health Republic Insurance of New York, Corp., Index No. 450500/2016

Dear Mr. Kirshnitz:

I represent Northwell Health Inc., a provider of health services to members of the Health Republic Insurance of New York, Inc. ("HIRNY") plans subject to the above referenced liquidation process. I have reviewed the memorandum prepared on behalf of the liquidator concerning the payment for out-of-network services directly to providers of such services.

Northwell concurs in the conclusions reached in the memorandum that:

A. The HRINY policies authorize the liquidator to make direct payments to the providers; and

B. Under New York law the Court may invalidate the anti-assignment provisions, which might preclude payment directly to the providers.

If you require any further information, please do not hesitate to contact me.

Sincerely,

Timothy F. Butler

TFB/sp

Exhibit C

In accordance with the Court's instruction at the conference before the Court on January 11, 2017, the following proposed notice will be published in the *New York Post* and the *New York Daily News* within twenty (20) days following the date of issuance of the accompanying Order to Show Cause.

NOTICE

IN THE MATTER OF THE LIQUIDATION OF
HEALTH REPUBLIC INSURANCE OF NEW YORK, CORP.
Supreme Court County of New York
Index No. 450500/2016

The Superintendent of Financial Services of the State of New York as liquidator ("Liquidator") of Health Republic Insurance of New York, Corp. ("Health Republic") has made an application to the Supreme Court of the State of New York, County of New York ("Court") seeking an order:

> **confirming that, notwithstanding the existence of an anti-assignment provision in a Health Republic insurance policy, the Liquidator may, where appropriate, make an allowed payment directly to a health care provider for the costs of covered services, whether the claim for payment was made by the policyholder, the health care provider, or both.**

The Court has set _____, ___ 2017 at _____ _.m. as the date and time for any interested parties to appear before the Court at the Courthouse, 60 Centre Street, New York, New York 10007, Room 438, and show cause why the requested relief should not be granted. If you wish to object to the Liquidator's application, you must serve upon the Liquidator a written statement setting forth your objection and all supporting documentation by _____, ___ 2017, at the following address:

Superintendent of Financial Services of the State of New York
as Liquidator of Health Republic Insurance of New York, Corp.
110 William Street, 15th Floor
New York, New York 10038
Attention: General Counsel

The application and its supporting documents are available at http://www.nylb.org and at www.healthrepublicny.org.

Exhibit D

At IAS Part 35 of the Supreme Court of the State of New York, County of New York, at the courthouse, 60 Centre Street, in the County, City and State of New York, on the ____ day of _____, 2017.

P R E S E N T :

HON. CAROL R. EDMEAD, J.S.C.

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In the Matter of

the Liquidation of

HEALTH REPUBLIC INSURANCE OF NEW YORK, CORP.

Index No. 450500/2016

ORDER

----------X

Maria T. Vullo, Superintendent of Financial Services of the State of New York as liquidator ("Liquidator") of Health Republic Insurance of New York, Corp. ("Health Republic"), moved this Court for an order confirming that, notwithstanding the existence of an anti-assignment provision in a Health Republic insurance policy, the Liquidator may, where appropriate, make an allowed payment directly to a health care provider for the costs of covered services, whether the claim for payment was made by the policyholder, the health care provider, or both.

NOW, upon reading the affirmation of Eliot Kirshnitz, an attorney for the New York Liquidation Bureau, the organization that carries out the duties of the Liquidator, and proof of service thereof upon all interested parties having been made, after due deliberation;

NOW, upon application of the Liquidator, it is

ORDERED, that, notwithstanding the existence of an anti-assignment provision in a Health Republic insurance policy, the Liquidator may, where appropriate, make an allowed

payment directly to a health care provider for the costs of covered services, whether the claim for payment was made by the policyholder, the health care provider, or both.

E N T E R

_____

J. S. C.