HEALTH CARE CERTIFICATE
OPPORTUNITY ACCESS PLUS

Preferred Assurance Company is pleased to supply you with this Opportunity Access Plus Certificate ("Certificate") that complements your coverage under your Opportunity Plan Health Care Certificate ("PC Certificate") with the Rochester Area Health Maintenance Organization, Inc., commonly known as "Preferred Care." Coverage under this Certificate will be provided by the Preferred Assurance Company, Inc. ("PAC"), an affiliate corporation of Preferred Care, 259 Monroe Avenue, Rochester, New York 14607. We can be reached by phone at (585) 325-3113 or (800) 950-3224. TTY users call (585) 325-2629 or (800) 252-2452.

Your PC Certificate provides comprehensive coverage for an extensive range of health care services rendered by Participating Providers. Therefore, you should always consider first receiving health care services through your PC Certificate and Preferred Care Participating Providers. Coverage under this Certificate is provided as a supplement to your Preferred Care coverage.

This Certificate covers you if you choose to receive certain Medically Necessary health care services covered by this Certificate from any provider (whether or not a Participating Provider of Preferred Care) but those services were not arranged for and approved in advance by your Primary Care Physician and Preferred Care. This Certificate does not provide for double payment for health care services which are covered under your PC Certificate, nor does it provide additional coverage in excess of the maximum level of benefits in the PC Certificate.

This Certificate is provided to each Employee enrolled in PAC through a Group Certificate. This Certificate is evidence of your coverage under the Group Certificate. Please note that this is not a contract between you and PAC. You should keep this document with your other important papers so that it is available for your future reference.

By enrolling in PAC and accepting this Certificate, you agree to abide by the rules as described herein. As a Member, you are eligible to receive Medically Necessary benefits described in this Certificate in exchange for the Premium paid to PAC.

Please take time to look over this Certificate. If you have any questions, please call us at the telephone numbers listed above. It is our goal to help you understand your health benefits. We look forward to serving you.

<u>THE ANNUAL BENEFITS UNDER THIS CERTIFICATE SHALL NOT EXCEED SEVENTY-FIVE THOUSAND DOLLARS ($75,000) PER MEMBER</u>

PREFERRED ASSURANCE COMPANY, INC.

President and Chief Executive Officer

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Part I – Definitions

A. **Active Treatment** means treatment furnished in connection with inpatient confinement for mental, nervous, or emotional disorders or ailments when all components of treatment are prescribed by a licensed physician and provided pursuant to a written comprehensive diagnostic or treatment plan.

B. **Calendar Year** means the twelve (12) month period beginning January 1 and ending December 31.

C. **Certificate** means this document, along with any Riders, your Enrollment Form, identification card, and any amendments added now or in the future. This Certificate explains the Covered Benefits and other terms of your PAC coverage.

D. **Coinsurance** means the percentage of Covered Expenses that are paid by the Member. Coinsurance amounts are described in this Certificate. Coinsurance amounts may be changed by us from time to time.

E. **Contract Year** means a period of time commencing at 12:01 A.M. Eastern Time on your Group's effective date and ending December 31st of the year in which the contract was issued, unless otherwise agreed to by the parties. Thereafter the contract will continue in force and automatically renew annually on January 1st unless otherwise terminated.

F. **Cosmetic** means a service or item whose purpose is to alter one's appearance without being Medically Necessary.

G. **Covered Benefits** means the health care services and items for which coverage is provided under this Certificate.

H. **Covered Expense** means the expenses for Covered Benefits incurred by a Member that will be reimbursed by us under the terms of this Certificate. Covered Expenses include only those charges for health care services and items that are less than or equal to our maximum allowable fees in effect at the time the service is rendered or the item is purchased. The Covered Expense may be established in accordance with a fee agreement, charges, "usual, customary and reasonable charges" or by statute or regulation. Except as expressly stated herein, in no event shall the Covered Expense exceed the lower of the Usual, Customary and Reasonable charges of the Provider or our maximum allowable fee. **Charges that are greater than our maximum allowable fees must be paid by you.** (Note: A Hospital may issue billing statements to Members that show amounts that are different than the Covered Expenses for a Covered Benefit. In certain situations, these charges do not represent the amount payable under this Certificate. The Covered Expenses and Coinsurance amount, if any, is determined by the agreement between the Provider and Preferred Care.)

I. **Custodial Care** means care that is primarily for the purpose of meeting personal needs and includes activities of daily living such as help in transferring, bathing, dressing, eating, using the toilet and such other related activities.

J. **Deductible** means the amount of Covered Expenses a Member must pay before claims for certain Covered Benefits are reimbursable under this Certificate.

K. **Dependent** means anyone in the Employee's family who meets the eligibility requirements described in the Eligibility, Enrollment and Effective Date of Coverage section of your PC Certificate and has been enrolled by the Employee.

L. **Durable Medical Equipment** means equipment that can withstand repeated use and is primarily and usually used for a medical purpose. This equipment is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home.

M. **Emergency Services** are Medically Necessary services provided in connection with an **Emergency Condition** defined as the sudden onset of an acute medical or behavioral condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical or surgical care to result in:
   1. Placing the health of the person afflicted, or in the case of a behavioral condition placing the health of such person or others, in serious jeopardy;
   2. Serious impairment to such person's bodily functions;
   3. Serious dysfunction of any bodily organ or part of such person; or
   4. Serious disfigurement of such person.

N. **Employee** means a person who meets the eligibility requirements as described in the Eligibility, Enrollment and Effective Date of Coverage section of your PC Certificate. To be covered, the Employee must complete an Enrollment Form and pay, or have paid on his or her behalf, all applicable Premiums. The Employee is the person to whom this Certificate is issued.

O. **Enrollment Form** means the document provided by you and/or the Group, either printed or in any other media, including electronic media, which provides the information required by us to enroll you and your Dependents under this Certificate.

P. **Experimental or Investigational Services and Items** mean services and items determined to be generally unaccepted by the medical community. When determining whether a service or item is Experimental or Investigational, we will use guidelines or rely upon determinations previously made by the medical community. Experimental or Investigational Services and Items are not covered under this Certificate unless required by an External Appeal recommendation.

Q. **Group** means the employer or other party that has entered into a Group Contract with us through which this Certificate is made available to eligible persons. The Group is not an agent of PAC.

R. **Group Contract** means the agreement between the Group and PAC through which Covered Benefits under this Certificate are provided.

S. **Group Open Enrollment Period** means a period of time established by the Group and us during which eligible persons, who have not previously enrolled with us, may do so. The Group Open Enrollment Period may change from time to time, but will occur at least once every twelve (12) months.

T. **Health Professional** means a person who is licensed, certified or otherwise qualified under a State's laws to provide the Covered Benefits authorized pursuant to such license, certification or other qualification.

U. **Home Health Agency** means an agency that provides Skilled Services and other therapeutic services in your home when Medically Necessary.

V. **Home Health Care** means the care and treatment of a Member who is under the care of a Participating Provider but only if:
   1. You are under the care of a physician who certifies the need for home health care and approves for its provision; and
   2. The care is provided by a home health care agency certified under Article 36 of the New York State Public Health Law or if provided outside the State of New York, under a similar certification process required by the State where Such services are provided; and
   3. You would otherwise need care in a Hospital or a skilled nursing facility

W. **Hospital** means an acute care Hospital licensed by the State and approved by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO) or by Medicare. A Hospital is not a Federal Hospital, a place primarily for the treatment of tuberculosis, a place of rest, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial or rehabilitory care.

X. **Maternity Care** includes care required by pregnancy, childbirth, abortions and miscarriages.

Y. **Medical Director** means a physician designated by PAC to monitor appropriate use of health services and quality of care.

Z. **Medically Necessary** Care (Medical Necessity/Medically Necessary) means the use of services or items, as described in this Certificate, required to identify or treat your illness or injury that meet all four of the conditions listed below. Medically Necessary Care is a Covered Benefit only when provided or arranged by a Health Professional. The fact that a Health Professional may prescribe, order, recommend, or approve a service or item does not, in itself, make the service or item Medically Necessary. The service or item must be:
   1. Consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury supported by a thorough examination, history, and tests;
   2. Appropriate, safe, and effective with regard to generally accepted standards of medical or surgical practice prevailing nationally or in the geographic locality, where and when the service or item is ordered;

3. Supported by a thorough, reasonable consideration of the treatment options available and a reasonable potential for therapeutic gain, and not solely for your appearance or recreation, or for the convenience of you, your Health Professional, Hospital, or other health care provider; and
4. Furnished in the least intensive, most cost efficient health care setting required. When applied to inpatient care, it further means that your medical symptoms or condition require that the diagnosis or treatment cannot be safely provided to you as an outpatient or in a less intensive environment.

AA. **Member** means any Employee or enrolled Dependent entitled to Covered Benefits under this Certificate.

BB. **Mental, Nervous or Emotional Disorders or Ailments** means a condition that Preferred Care determines
1. is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and
2. substantially or materially impairs a person's ability to function in one or more major life activities; and
3. has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

CC. **Mental Health Services** means medically necessary care rendered by an eligible practitioner or approved facility and which, in the opinion of Preferred Care, is directed predominantly at treatable behavioral manifestations of Mental, Nervous or Emotional Disorders or Ailments.

DD. **Orthotics** means an orthopedic appliance or apparatus used to support, align, prevent or correct deformities; or to improve the function of movable body parts (i.e. a device to assist a dysfunctional joint).

EE. **Partial Hospitalization Program** is a program which shall provide Active Treatment designed to stabilize and improve acute symptoms, to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program. Eligibility for admission is based on a designated mental illness diagnosis. The program shall provide assessment and health screening services to all recipients. Treatment planning and discharge planning services shall be in accordance with Section 587.16 of the Office of Mental Health Regulations

FF. **Participating Provider** means a Health Professional, a supplier of health care services or items, or a health care facility that has an agreement with Preferred Care to provide health care services or items to Preferred Care Members.

GG. **Plan** means any coverage for health care services or items provided under any insurance policy or contract, prepaid health plan or contract, government health benefit program or health benefit plan under the Employee Retirement and Income Security Act (ERISA).

HH. **Pre-Certification** means that, in order for certain services or items to be a Covered Benefit, certification or authorization must be obtained from PAC.

II. **Premium** means the periodic payment (usually monthly) made to us on your behalf that entitles you to the benefits in this Certificate.

JJ. **Prior Justification** is a subset of Pre-Certification that involves clinical review and authorization, by the PAC Medical Director or designee, of requests for certain services or items made by you or on your behalf. Authorization must be obtained before the service or item is received in order to be Prior-Justified.

KK. **Professional Services** means services (except as excluded or limited in this Certificate) performed by Health Professionals that are Medically Necessary, generally recognized as appropriate care, and in accordance with our policies and procedures.

LL. **Prosthetics** means devices that replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ or part. There are two types of prosthetics: internal and external. Internal prosthetics are implanted into or permanently attached to the body. External prosthetics are readily removable and do not become a permanent part of the body.

MM. **Riders** mean amendments to this Certificate that change the benefits made available to the Group. Riders are subject to applicable underwriting requirements and Premium rates. Such Riders, when purchased by the Group, will be included with and become a part of this Certificate.

NN. **Service Area** means the counties of Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, and Yates in the State of New York The Service Area may be expanded with the approval of the appropriate Federal and State agencies.

OO. **Skilled Nursing Facility** means a facility that is specially qualified to provide inpatient medical and nursing care. The facility must be recognized and certified as such by Medicare, and fall within the definition of a Skilled Nursing Facility under Title XVIII of the Social Security Act.

PP. **Skilled Services** means Skilled Nursing or Skilled Rehabilitation services rendered in a Skilled Nursing Facility or in a Hospital.

1. Skilled Nursing care means care that can be performed only by, or under the supervision of, licensed nursing personnel on a daily basis. (This may be on an intermittent basis for Members receiving home care).
2. Skilled Rehabilitation (Physical and Occupational Therapy) means therapy that can be performed only by, or under, the supervision of a professional physical or occupational therapist on a daily basis which leads to a higher level of functioning. (This may be on an intermittent basis for Members receiving home care).

QQ. **We, Our or Us** refers to PAC.

RR. **You or Your** refers to you (Employee/Member) and your eligible enrolled Dependent(s).

Part II - Eligibility, Enrollment and Effective Date of Coverage

This Certificate duplicates the eligibility, enrollment, and effective and renewal date provisions of your PC Certificate.

Part III - Services and Benefits

General Provisions

Unless excluded or limited by the Exclusion, Limitations and Non-covered Services section of this Certificate, you are eligible to receive the following medical, surgical, diagnostic, and therapeutic, services and items, provided that:

1. You or your Dependents follow our rules and procedures as described in this Certificate;
2. The services and benefits are not otherwise eligible as Covered Expenses under your PC Certificate;
3. The services and benefits are Medically Necessary; and
4. The services and benefits are rendered by a Health Professional.

PAC will not cover any health service or item that we determine is not Medically Necessary, unless specified in the Services and Benefits section of this Certificate. We will cover a service or item for which coverage had been denied for lack of Medical Necessity only if required by an External Appeal Agent certified by the State of New York. Coverage would then be provided only to the extent that such service or item is otherwise covered under the terms of this Certificate. (For further information on external appeals, please consult your Preferred Care Member Handbook.)

Coverage under this Certificate does not provide additional coverage in excess of the maximum level of benefits in your PC Certificate. For example, your PC Certificate limits Outpatient Chemical Abuse / Chemical Dependence to sixty (60) visits per Calendar Year, as does this Certificate. This means you have a maximum of sixty (60) covered visits per Calendar Year that can be used under either this Certificate or divided between this Certificate and your PC Certificate. It does not mean that you have coverage for one-hundred twenty (120) visits. If you have any questions regarding this, please contact our Member Services Department.

A. Doctors and Other Health Professional Services.

Coverage is provided for:

1. *Office Visits*. Services for the diagnosis, and treatment of illness or injury when provided in the medical office of the Health Professional.
2. *Hospital Services*. Services of Health Professionals for diagnosis, treatment, consultation, surgery and anesthesia are provided while you are receiving inpatient care covered under this Certificate. Services include a second surgical opinion on the need for surgery by a qualified Health Professional, whether in the Hospital or in the medical office of the Health Professional.
3. *Outpatient Services*. Services for the diagnosis and treatment of illness or injury in an outpatient setting by a Health Professional. Services include surgery, anesthesia, radiation therapy, chemotherapy, dialysis treatments, respiratory therapy, and cardiac rehabilitation therapy.
4. *Physician Home Visits*. Home visits provided by a Health Professional when indicated by the nature of the illness or injury.
5. *Allergy Care*. Allergy testing, evaluation, injection, and serum when provided by a Health Professional.
6. *Chiropractic Services*. Chiropractic Services are defined as the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purposes of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Preferred Care will only cover Medically Necessary chiropractic care. Maintenance treatment for conditions that does not result in significant clinical improvement or lead toward resolution of the condition is not a Covered Benefit.
7. *Plastic and Reconstructive Surgery.*
   a. Plastic and reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or when there is a congenital disease or anomaly which has caused a functional defect, but only when the surgery is reasonably expected to correct the condition.
   b. Breast Reconstruction. All stages of reconstruction of a breast on which a mastectomy has been performed. Coverage is also provided for surgery and reconstruction of the other breast to produce a symmetrical appearance, in the manner determined by the Health Professional and the patient to be appropriate.
8. *Second Opinions for Cancer*. A second opinion by an appropriate Specialist in the event of:
   a. A positive or negative diagnosis of cancer,
   b. A recurrence of cancer, or
   c. A recommendation of a course of treatment for cancer.

   An appropriate Specialist includes, but is not limited to; a Specialist affiliated with a specialty care center for the treatment of cancer.

Coverage for Professional Services is limited to 60% of Covered Expenses after meeting applicable Deductibles.

B. Emergency Care and Pre-Hospital Emergency Services.

1. *Emergency Care.* Coverage is provided for Emergency Services as defined in the Definition section of this Certificate. **You , a prudent layperson, are not required to obtain prior approval before seeking Emergency Services. Coverage will be provided In-network or Out-of-Network. In the event that you are faced an Emergency Condition you should go directly to the emergency room.**

   While it is not necessary for you to contact your Primary Care Physician prior to receiving Emergency Services, you or a designee should notify your Primary Care Physician within forty-eight (48) hours AFTER receiving care, or as soon as reasonably possible if there are extenuating circumstances, so that your Primary Care Physician can coordinate any necessary follow-up care. Remember, your Primary Care Physician knows your health history and provides physician on-call coverage twenty-four (24) hours a day, three hundred sixty-five (365) days a year. The physician on-call will help you determine the most appropriate course of treatment.

   Preferred Care will not cover services performed in an emergency room unless they are Medically Necessary and in connection with an emergency condition.

   Out-of-Network Services required as a result of circumstances which could have been foreseen prior to leaving the Service Area, including elective, routine or specialized care, are covered only when they are authorized by the Primary Care Physician and Pre-Certified by our Medical Director or designee before services are received.

   If you are hospitalized for Emergency Services in a Hospital that is a non-Participating Provider or an Out-of-Network Hospital, Preferred Care may require that you be transferred to a Hospital that is a Participating Provider or other facility within the Service Area as soon as medically possible.

   When receiving Emergency Services, the Hospital may (with approval from Preferred Care) keep you for up to forty-eight (48) hours for observation/post-stabilization. This is not a hospital inpatient admission; it is an alternative level of care.

2. *Ambulance Services.* Coverage is provided for Medically Necessary ambulance services provided by a Hospital, professional or licensed ambulance service for the following :

   a. Pre-hospital Emergency Services and Transportation:

      (1) Pre-hospital emergency services means the prompt evaluation and treatment of an Emergency Condition as defined in the Definition section of this Certificate.

      (2) Pre-hospital Emergency Transportations means non-air- borne transportation of the patient to a hospital due to an Emergency Condition as defined in the Definition section of this Certificate. The ambulance must transport you to the nearest Facility for an inpatient admission or emergency outpatient care. If the nearest Facility cannot treat your disability or condition, we will provide coverage for ambulance services to the nearest Facility that can render the treatment you need.

   b. Medically necessary transport between facilities.

   c. For non-emergency transport only when Prior Justified; or

   d. When ordered by an employer, school or public safety official, or when you are not in a position to refuse the service.

Coverage for Emergency Care and Pre-Hospital Emergency Services can be found in your PC Certificate and "Explanation of Benefits and Copayments". These services will be covered as In-network.

C. Health Maintenance and Preventive Services.

Coverage is provided for the following health maintenance and preventive services:

1. *Bone Mineral Density measurements or tests* Coverage is provided for bone mineral density measurements or tests for the following:
   a. Members meeting the criteria for coverage consistent with the criteria under the federal Medicare program or the criteria of the National Institutes of Health,
   b. Members previously diagnosed as having osteoporosis or having a family history of osteoporosis,
   c. Members with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis,
   d. Members on a prescribed drug regimen posing a significant risk of osteoporosis,
   e. Members with lifestyle factors to such a degree as posing a significant risk of osteoporosis, or
   f. Members with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.
2. *Gynecological Exams.* Biannual (twice a year) gynecological examination and pap smears.
3. *Immunizations and Vaccinations.* Immunizations and vaccinations according to generally accepted medical practice standards. Covered immunizations and vaccinations for children are those recommended by the Advisory Committee on Immunization Practices. The immunization schedule can be found in your Member Handbook and an updated schedule is included annually in our member newsletter. Your PCP will help you to determine the best time for your child to receive these immunizations.
4. *Mammography Screening.* Mammography screening for occult breast disease is covered under the following conditions:
   a. On the recommendation of a Health Professional, a mammogram at any age for a Member having a prior history of breast cancer or who have a first degree relative (parent, child, sibling) with a prior history of breast cancer;
   b. A single baseline mammogram for Members age thirty-five (35) through thirty-nine (39) inclusive;
   c. An annual mammogram for Members age forty (40) and over.

   No more than one (1) routine mammography screening will be covered during a Calendar Year.
5. *Prostate Screening.* Prostate screening for occult prostate disease is covered under the following conditions:
   a. on the recommendation of a Physician, standard diagnostic testing including but not limited to, a digital rectal exam and Prostate-specific antigen (PSA) test at any age for a Member having a prior history of prostate cancer;
   b. standard diagnostic testing including but not limited to, an annual digital rectal exam and Prostate-specific antigen (PSA) test for Members age forty (40) through forty-nine (49) inclusive with a family history of prostate cancer or other prostate cancer risk factors; and
   c. standard diagnostic testing including but not limited to, an annual digital rectal exam and Prostate-specific antigen (PSA) test for Members age fifty (50) and over.
6. *Well-Child Visits.* Well child visits through age eighteen (18), according to American Academy of Pediatrics guidelines.

Coverage for Health Maintenance and Preventive Services is limited to 60% of Covered Expenses after meeting applicable Deductibles.

D. Home Health Services.

1. *Home Health Services.* Coverage is provided for in-home services by Health Professional when Prior Justified by Preferred Care (except for agencies with contractual exclusions from Prior Justification). Coverage is limited to forty (40) visits per Member per Calendar Year. Each visit by a member of a home care team is counted as one (1) home care visit. Up to four (4) hours of home health aide service are counted as one (1) home care visit. Coverage is provided for the following services:

a. Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.),
b. Part-time or intermittent home health aide services which consist primarily of caring for the patient,
c. Physical, occupational or speech therapy if provided by the home health agency, and
d. Medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a home health agency to the extent such items or services would have been covered or provided under this Certificate if the Member had been hospitalized or confined in a Skilled Nursing Facility.

Coverage for Home Health Services is limited to 60% of Covered Expenses after meeting applicable Deductibles.

E. Hospital Services.

This Certificate limits coverage for inpatient Hospital care in the following way:
Pre-Certification/ Prior Justification is required. If you require hospitalization for services covered under this Certificate, you or your authorized representative must notify PAC and/or obtain the prior approval of PAC's Medical Director at least five (5) days before you are admitted to the Hospital. **You, not your physician, are responsible for obtaining such approval**. You must call our Member Services Department or write to PAC at the phone numbers and address listed on the front cover of this Certificate. If you fail to receive prior approval before you are admitted to a Hospital, coverage will be limited to 50% of Covered Expenses, after meeting applicable Deductibles.

1. *Inpatient Services*. Coverage is provided for the following inpatient services:
   a. Semi-private room and board, with no limit to number of days, in some circumstances, except for chemical abuse/ chemical dependence inpatient services as described in this Certificate. Length of stay for inpatient care following a lymph node dissection, lumpectomy for the treatment of breast cancer, or a covered mastectomy will be determined by the Health Professional in consultation with the Member.
   b. Private rooms are covered only when Medically Necessary. If you occupy a private room for any reason other than Medical Necessity, you must pay any difference between the cost of the private room and the cost of a semi-private room.
   c. Laboratory, x-ray, and other diagnostic services.
   d. Drugs, medications, biologics, and their administration.
   e. Use of operating and delivery rooms and related facilities.
   f. Oxygen services.
   g. Physical therapy and other rehabilitation services required as part of an approved Hospital stay, limited to services anticipated to result in significant clinical improvement within a reasonable period of time.
   h. Radiation therapy, chemotherapy and dialysis.
   i. Breast prostheses and complications of the mastectomy, including lymphedema.
   j. Blood and blood plasma and their administration.
2. *Pre-Admission Testing*. Coverage is provided for tests that must be performed before you are admitted to a Hospital for surgery. The tests must meet the following conditions:
   a. They must be consistent with the diagnosis and treatment of the condition for which surgery is to be performed.
   b. You must have a reservation for the Hospital bed and for the operating room before the tests are given.
   c. You must be physically present at the Hospital when the tests are given.
   d. Surgery must actually take place no more than seven (7) days after the tests are performed.

3. *Outpatient Services.* Coverage is provided for the following services through a Hospital outpatient department:
   a. Radiation therapy, chemotherapy and dialysis,
   b. Diagnostic tests and procedures,
   c. Short-term rehabilitation services limited to services which result in significant clinical improvement within a reasonable period of time, and
   d. Outpatient surgery.

   Coverage for Hospital Services is limited to 60% of Covered Expenses after meeting applicable Deductibles. Coverage is limited to 50% of Covered Expenses, after meeting applicable Deductibles, if you fail to receive prior approval before you are admitted to a Hospital.

F. Laboratory and X-ray Services (includes pre-admission testing).

Coverage is provided for the following services performed in an outpatient setting:

1. *Laboratory services.* Tests performed in an outpatient setting, regardless of where the specimen was taken (e.g. in a physician's office).
2. *X-rays.* Services provided in a free-standing or Hospital-based X-ray facility. Diagnostic radiological procedures, including, but not limited to, x-ray examinations, magnetic resonance imaging (MRI's), magnetic resonance angiography (MRA's), computerized axial tomography (CT scans), computerized tomographic angiography (CT angiography), positron emission tomography (PET scans), fluoroscopy, and ultrasounds.
3. *Bone Mineral Density* measurements or tests. Coverage is provided for bone mineral density measurements or tests for the following:
   a. Members meeting the criteria for coverage consistent with the criteria under the federal Medicare program or the criteria of the National Institutes of Health,
   b. Members previously diagnosed as having osteoporosis or having a family history of osteoporosis,
   c. Members with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis,
   d. Members on a prescribed drug regimen posing a significant risk of osteoporosis,
   e. Members with lifestyle factors to such a degree as posing a significant risk of osteoporosis, or
   f. Members with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.
4. *Mammography Screening.* Mammography screening for occult breast disease is covered under the following conditions:
   a. On the recommendation of a Health Professional, a mammogram at any age for Members having a prior history of breast cancer or who have a first degree relative (parent, child, sibling) with a prior history of breast cancer;
   b. A single baseline mammogram for Members age thirty-five (35) through thirty-nine (39) inclusive; and
   c. An annual mammogram for Members age forty (40) and over.
      No more than one (1) routine mammography screening will be covered during a Calendar Year.

   Coverage for Laboratory and X-ray services is limited to 60% of Covered Expenses after meeting applicable Deductibles.

G. Maternity and Family Planning Services.

Coverage is provided for the following maternity and family planning services:

1. *Maternity Care.* Coverage is provided for care required by childbirth (including prenatal and postnatal care), abortions and miscarriages. This includes use of Hospital delivery rooms and related facilities; use of newborn nursery and related facilities; Professional Services related to the delivery; and special procedures as determined by a Health Professional. Coverage for inpatient confinement includes:

a. The mother and newborn for at least forty-eight (48) hours after childbirth for any delivery other than a cesarean section and for at least ninety six (96) hours after a cesarean section.
b. Parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.
c. One maternity home health service visit if requested and if the mother and child are discharged earlier than provided in paragraph “a” above due to an agreement between the mother and her physician. The visit may be requested any time within forty-eight (48) hours of the delivery (ninety-six (96) hours in case of cesarean section) and shall be delivered within twenty-four (24) hours after discharge or at the time the mother requests, whichever is later. No Copay or Coinsurance will be required for such a maternity home health service visit.

2. *Family Planning Services.* Coverage is provided for diagnosis, counseling, and services related to fertility and infertility as follows:
   a. Coverage of services related to infertility for the diagnosis and treatment of correctable medical conditions.
   b. Hospital care and surgical and medical procedures provided as part of such hospital care that would correct malfunction, disease, or dysfunction resulting in infertility.
   c. Surgical and medical procedures that would correct malfunction, disease, or dysfunction resulting in infertility.
   d. Diagnostic tests and procedures, including those tests and procedures provided as part of hospital care, that are necessary to determine infertility or that are necessary in conjunction with any surgical or medical treatments or prescription drug coverage. Such covered tests and procedures include, but are not limited to hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sonohysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound.
   e. There is no coverage for infertility drug treatment under this Certificate. Infertility drug treatment is covered under your pharmacy Rider, if any.
   f. There is no coverage for services for the diagnosis and treatment of infertility in connection with:
      (1) in vitro fertilization
      (2) gamete intrafallopian tube transfers
      (3) zygote intrafallopian tube transfers
      (4) the reversal of elective sterilizations
      (5) sex change procedures
      (6) cloning; or
      (7) medical or surgical services or procedures that are deemed to be experimental in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine
   g. Pregnancy terminations (abortions) are covered when performed in accordance with the laws of the State of New York.
   h. A Member’s first voluntary sterilization is a Covered Benefit. Reversals and subsequent sterilizations are not covered.

Coverage for Maternity and Family Planning Services is limited to 60% of Covered Expenses after meeting applicable Deductibles.

H. Mental Health and Chemical Abuse / Chemical Dependence Services

Coverage is provided for Mental Health Services and Chemical Abuse / Chemical Dependence Services described below. If you receive Mental Health Services or Chemical Abuse/ Chemical Dependence Services through an Emergency Room please refer back to your PC Certificate for the application of the benefit. If you require Hospitalization for Mental Health Services under this Certificate, you or your authorized representative must notify PAC and/or obtain Pre-Certification before you are admitted to the hospital. **You, not your physician, are responsible for obtaining such approval.** You must call us at (585) 327-2477 or toll free at 1(800) 836-1430 before receiving services. If you fail to receive prior approval before you are admitted to a Hospital, coverage will be limited to 50% of Covered Expenses, after meeting applicable Deductibles.

1. *Inpatient Mental Health Services*
   Inpatient Mental Health Services used in the Active Treatment of Mental, Nervous or Emotional Disorders or Ailments are limited to a maximum of thirty (30) inpatient days per Member per Contract Year. You may convert inpatient days to cover partial hospitalization days on a two to one basis.
   a. *Covered Facilities for Treatment.* For Covered Services accessed within New York State, for purposes of this subsection, "Hospital" is defined as the inpatient services of a psychiatric center under the jurisdiction of the office of mental health or other psychiatric in-patient facility in the department, a psychiatric in-patient facility maintained by a political subdivision of the State for the care or treatment of the mentally ill, a ward, wing, unit, or other part of a Hospital, as defined in Article 28 of the Public Health Law, operated as part of such Hospital for the purpose of providing services for the mentally ill pursuant to an operating certificate issued by the Commissioner of Mental Health, or other facility providing an operating certificate by the Commissioner. For Covered Services accessed outside New York State, comparable legislation will be reviewed.
2. *Outpatient Mental Health Services*
   Outpatient Mental Health Services used in the treatment of Mental, Nervous or Emotional Disorders or Ailments are limited to twenty (20) visits per Member per Contract Year.
   a. *Covered Facilities for Treatment.* Coverage is limited to facilities operated by the Office of Mental Health; a facility issued an operating certificate by the Commissioner of Mental Health pursuant to the provisions of Article 31 of Mental Hygiene Law; or a psychiatrist, psychologist, licensed clinical social worker, or a professional corporation or university faculty practice corporation pursuant to the requirements of Section 4303(n) of the New York State Insurance law or comparable legislation outside of the State of New York.
3. *Chemical Abuse / Chemical Dependence Services.*
   a. *Inpatient/Outpatient Detoxification.* Includes a stay in a semi-private Hospital room and Professional Services relating to detoxification of chemical abuse/chemical dependence when rendered in a facility approved by us. Services are limited to a maximum of seven (7) inpatient days per Member per Calendar Year. You may convert up to seven (7) inpatient days to cover outpatient detoxification services when medically appropriate. For the conversion, one (1) inpatient detoxification day is equal to two (2) days of outpatient detoxification services with a Participating Provide.
   b. *Outpatient Chemical Abuse / Chemical Dependence Services.* Coverage is provided for Professional Services for outpatient chemical abuse/chemical dependence including diagnostic evaluations to determine the nature and extent of your illness, counseling, and active therapy. These services are limited to sixty (60) visits per Member per Calendar Year. Up to twenty (20) of the sixty (60) visits may be used by covered family members for family therapy related to the Member's chemical abuse/chemical dependence. The purpose of these visits is to aid in the understanding of the illness and to help the family members play a meaningful role in the recovery. Payment for family therapy sessions will be the same amount, regardless of the number of family members who attend the family therapy session. The recipient of the outpatient Chemical Abuse/Chemical Dependence services does not have to be a Preferred Care Member for family members to receive family

services. Coverage is not provided for outpatient services that consist primarily of participation in programs of a social, recreational, or companionship nature.

c. *Other Services*. No coverage is provided for ancillary services resulting from chemical abuse / chemical dependence unless they are Medically Necessary. However, determination of the need for those services is covered. Also, no coverage is provided for inpatient diagnosis or rehabilitation of chemical abuse / chemical dependence.

d. *Treatment Authorization/Plan*. You are required to call PAC at (585) 327-2477 or toll free at 1(800) 836-1430 to receive authorization for treatment. Once authorization is received, the facility where you receive treatment must submit a treatment plan to PAC for its approval within ten (10) days after you begin treatment. If a treatment plan is not submitted within ten (10) days, or if we do not approve the treatment plan, payment will not be made for any visit which takes place more than ten (10) days after you begin treatment.

e. *Covered Facilities for Treatment.* You are covered for treatment of alcoholism in New York State only if the facility where the outpatient visit takes place is certified by the New York State Division of Alcoholism and Alcohol Abuse to provide an alcohol treatment program. Coverage for chemical abuse / chemical dependence will be limited to facilities that are certified to provide medically supervised ambulatory chemical abuse / chemical dependence programs by the Division of Substance Abuse Services in New York State. If you receive treatment outside of New York State, the facility must be accredited to provide a chemical abuse/chemical dependence treatment program by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A person whose primary diagnosis is chemical abuse / chemical dependence may be treated only in a facility approved by the Division of Substance Abuse Services. A person whose primary diagnosis is alcoholism may be treated only in a facility certified by the Division of Alcoholism and Alcohol Abuse.

Coverage for Mental Health Services and Chemical Abuse / Chemical Dependence Services is limited to 60% of Covered Expenses after meeting applicable Deductibles. Coverage is limited to 50% of Covered Expenses, after meeting applicable Deductibles, if you fail to receive prior approval before you are admitted to a Hospital

I. Special Services, Equipment and Devices.

1. *Diabetic Coverage.*

Coverage for the treatment of diabetes includes:

a. *Diabetes equipment and related supplies. .* Includes glucose monitors and glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin and injection aids, cartridges for the visually impaired, syringes, insulin pumps and accessories, insulin infusion devices and oral agents for controlling blood sugar and other additional diabetes equipment and related supplies that are Medically Necessary for the treatment of diabetes as required by rules and regulations of the New York State Department of Health. Diabetes equipment must be prescribed by a Health Professional, Pre-Certified and purchased from a Participating Provider.

b. *Professional Services Consisting of Diabetes Self-Management Education*. If you are diabetic, coverage will be provided for education to ensure you are trained in the proper self-management and treatment of your condition, including information on proper diets. Such education will be limited to visits when there is a diagnosis of diabetes, where a Health Professional diagnoses a significant change in your symptoms or conditions necessitating changes in self-management, or where reeducation or refresher education is necessary. Education provided by certified diabetes educators, certified nutritionists, certified dietitians, or registered dietitians will be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet will also include home visits when Medically Necessary.

c. *Insulin and Oral Agents for Controlling Blood Sugar*. Up to a one (1) month supply at participating retail drug locations.

2. *Prosthetic Devices.*
   Coverage is provided for Prosthetics as defined in the Definition section of this Certificate. Covered devices must be prosthetics as defined by Medicare.
   a. *Internal Prosthetics.* Coverage is provided for Internal Prosthetics including, but not limited to, pacemakers, heart valve replacements, and artificial joints.
   b. *External Prosthetics.* Coverage for external breast prosthetics only is provided under this Certificate.
   c. *Dental Prosthetics.* Internal or external dental Prosthetics are only covered when supplied in conjunction with a covered dental service as described in the Services and Benefits section of this Certificate.

   Coverage is provided only for the basic prosthetic and any Medically Necessary special features. Replacements are limited to those necessary due to normal wear and use and body growth/change. There is no coverage for Prosthetic Devices that have been abused or cared for improperly.
3. *Provider Administered Prescription Medications.*
   a. Provider Administered Prescription Medications are covered in an outpatient setting when it is Medically Necessary that the medication be provider administered.
   b. A copay will apply to the medication.
      (1) The medication copay will apply only when a separate charge is made to Preferred Care for the medication (e.g. if the medication is included in the fee for the office visit, a separate medication copay will not apply).
      (2) The medication copay will be in addition to any other copay taken that day (e.g. an office visit copay).
      (3) One medication copay will apply for all medications administered by a provider on a date of service.
      (4) The medication copay will not apply to immunizations, vaccinations, allergy serum, or drugs covered under your pharmacy Rider or Home Health Services benefit.

Coverage for Special Services, Equipment, and Devices is limited to 60% of Covered Expenses after meeting applicable Deductibles.

J. Treatment for Accidental Injuries to Teeth and Non-Dental Oral Surgery.

General dental services and dental services related to temporomandibular joint conditions (TMJ), unless Medically Necessary, or treatment of the teeth, extraction of teeth, orthodontia, treatment of dental abscesses, treatment of gingival tissues (other than for tumors), dental appliances, dental devices (other than those described in the Services and Benefits section of this Certificate), and dental examinations are not Covered Benefits unless provided in an inpatient or outpatient setting as part of the:

1. Treatment for accidental injury to sound natural teeth, the jaw bones or surrounding tissues within twelve (12) months of the accident as long as you are a Member at the time services are rendered.
2. Treatment or correction of a non-dental physiological condition that has resulted in severe functional impairment.
3. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
4. Treatment necessary due to congenital disease or anomaly.

Notwithstanding the above paragraph, medical treatment (not dental services) related to temporomandibular joint conditions (TMJ) are Covered Benefits.

Coverage for Treatment for Accidental Injuries to Teeth and Non-Dental Oral Surgery is limited to 60% of Covered Expenses after meeting applicable Deductibles.

Part IV -Deductible, Coinsurance, Out-of-Pocket Maximum, and Maximum Annual Benefits

A. **Deductible.** Before you are entitled to reimbursement for Covered Benefits under this Certificate, you must pay an annual Deductible as follows:

1. The Deductible for individuals is the first **$600** of Covered Expenses incurred in each Calendar Year. Once you have met your Deductible, you are entitled to reimbursement of **60%** of your Covered Expenses.
2. The maximum Deductible for a family is the first **$1500** incurred in each Calendar Year. Once the Covered Expenses paid by the family for all Members combined reaches **$1500**, whether or not any individual Deductible is met, all Members are entitled to reimbursement of **60%** of their Covered Expenses.

B. **Coinsurance.** Unless otherwise specified in this Certificate, you are entitled to reimbursement of **60%** of Covered Expenses after the applicable Deductible specified in paragraph A above has been met. You must also pay the remaining **40%** Coinsurance, plus any charges for health services which are not Covered Expenses under this Certificate, plus any non-notification penalty, if applicable.

C. **Out-of-Pocket Maximum.** Individuals are not required to pay more than **$3,000** of Coinsurance and Deductible amounts in any Calendar Year. Families are not required to pay more than **$6,000** of Coinsurance and Deductible amounts in any Calendar Year. Once the Out-of-Pocket Maximum in any Calendar Year has been paid, coverage will be provided for **100%** of Covered Expenses for the remainder of the Calendar Year. Deductibles, Coinsurance, and Copayments paid under any additional Riders purchased by the Group cannot be applied towards the Preferred Assurance Company maximum Out-of-Pocket amounts. The Out-of-Pocket Maximum will not apply to pharmacy expenses provided under a pharmacy Rider.

D. **Maximum Annual Benefit.** We will not make any further payments under this Certificate after we have paid Covered Expenses which total **$75,000** in any Calendar Year.

E. **Non-Covered Expense Amounts.** Amounts that are not Covered Expenses will not apply toward the Deductible, Coinsurance or Out-of-Pocket Maximum.

F. **Non-Notification Penalty Amounts.** Non-notification penalty amounts are Non-Covered Expenses and will not apply toward the Deductible, Coinsurance or Out-of-Pocket Maximum.

G. **Amounts Paid under the PC Certificate.** Any amounts paid under the PC Certificate will not be applied towards the PAC Deductible, Out-of-Pocket Maximum, or Maximum Annual Benefit set out in this section.

Part V - Exclusions, Limitations and Non-Covered Services

A. Certificate Exclusions.

Except as described under the Services and Benefits section of this Certificate, the following services are not Covered Benefits:

1. Acupuncture.
2. Any services or care for which coverage is provided under your PC Certificate.
3. Benefits provided under any employer's liability or occupational disease law.
4. Chemical abuse / chemical dependence services except as described in the Services and Benefits section of this Certificate.
5. Contraceptives.
6. Cosmetic Surgery- Any cosmetic surgery or procedure or any related service, except as described in the Services and Benefits section of this Certificate or Medically Necessary due to medical complications of a Cosmetic surgery or otherwise Medically Necessary.
7. Dental Care, including but not limited to treatment of the teeth, extraction of teeth, treatment of dental abscesses, treatment of gingival tissues (other than for tumors), dental examinations and any other dental product, service or item except as described in the Services and Benefits section of this Certificate.
8. Durable Medical Equipment (DME), except as described in the Diabetic Coverage and Home Health Services sections of this Certificate.
9. External Prosthetics other than external breast prosthetics.
10. Eye Care. Routine eye exams, eyeglasses and contact lenses.
11. Family Member. Services performed by a member of the Member's immediate family.
12. Foot Care. Routine Foot Care including services or care in connection with any of the following: corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.
13. Government Hospital. Treatment provided in a government Hospital, except for Emergency Services which are covered under your Preferred Care Certificate.
14. Government Programs. Benefits for which coverage is available to you under any government program, except Medicaid.
15. Hearing aids, hearing exams, and procedures for prescription or fitting of hearing aids.
16. Hospital Employee. Services rendered and separately billed by employees of Hospitals, laboratories or other institutions.
17. Medical Supplies except as described in the Diabetic Coverage and Home Health Services sections of this Certificate.
18. Mental health and psychiatric treatment, services or treatment for mental retardation or chronic mental illness or enrollment in special schools, except as described in the Services and Benefits section of this Certificate.
19. No-fault. Benefits for which coverage is available under mandatory no-fault automobile insurance. This is true even if you choose not to file a claim for coverage under the mandatory no-fault automobile insurance.
20. Non-covered Services. Any service, care, supply or equipment which is not specifically covered under the Services and Benefits section of this Certificate.
21. Orthotics (including custom made foot orthotics).
22. Payment for services that would normally be provided without charge.
23. Personal growth and/or educational requirements in conjunction with the mental health and chemical abuse / chemical dependence benefits.

24. Prescribed drugs and medications except as provided while confined as an inpatient or provided for diabetic care.
25. Pretrial or court testimony, court-ordered treatment, including but not limited to, treatment for chemical abuse / chemical dependence or a mental condition and the preparation of court related reports are not a benefit, unless Medically Necessary and otherwise covered under this Certificate.
26. Rest cures.
27. Reversal of voluntary sterilization.
28. Services provided in conjunction with services or items that are not Covered Benefits, except as described in the Services and Benefits section of this Certificate.
29. Skilled Services except as provided by a Home Health Agency
30. Transportation, except as provided in your Preferred Care Certificate.
31. Treatment of an illness, accident or condition arising out of your participation in a felony . The felony will be determined by the law of the state where the criminal behavior occurred. If coverage is provided to you prior to our knowing that the need for services arose out of a felony, you agree that you will reimburse to us the amount we paid to cover the cost of any such services
32. Treatment of an illness, accident or medical condition arising out of: participation in a riot, or insurrection, war or act of war (whether declared or undeclared), and service in the Armed Forces or auxiliary thereto.
33. Workers' Compensation. Benefits to the extent that they were provided under the Workers' Compensation Law.

B. Medically Necessary Exclusions.

The following services are not Covered Benefits because they do not meet the definition of Medically Necessary Care:

1. Custodial Care unless provided in conjunction with Skilled Services as a component of approved Home Care Services as described in the Services and Benefits section of this Certificate.
2. Experimental or Investigational Services and Items that are not recognized to be therapeutically effective. An Experimental or Investigational Service or Item not recognized to be therapeutically effective is one which utilizes any technology that requires federal or government agency approval which was not granted at the time services were rendered. Other services or items not recognized as therapeutically effective are services or items requiring the use of technology that requires federal or government agency approval, services or items for which approval may have been granted but the service or item has been determined by the medical community for which the service or item was used to be outdated, outmoded, or otherwise no longer considered to be reasonably effective to treat the specific condition. The term "technology" refers to any medical or surgical treatment, medical or surgical device, therapeutic or diagnostic service or item, drug, biological, therapeutic or diagnostic agent. The final determination of whether a service or item is considered Experimental or Investigational or not recognized as therapeutically effective is based upon a review of the appropriate medical authority.
   a. In making this determination, our medical professionals, chosen solely by us, will evaluate each service or item considering criteria such as, but not limited to how Medicare would treat the service or item for coverage considering:
      (1.) Whether the technology has final approval from the appropriate government regulatory bodies;
      (2.) Whether the scientific evidence permits conclusions concerning the effect of the technology on health outcome;
      (3.) Whether the technology improves the net health outcome;
      (4.) Whether the technology is as beneficial as any established alternatives; and

(5.) Whether improvement must be attainable outside the experimental or investigational setting.

The same criteria will be used to evaluate each service or item. No benefits will be provided for a service or item if the service or item is determined to be an Experimental or Investagational service or item or not recognized as therapeutically effective.

In general, we do not cover Experimental or Investigational treatments, services or items. However, we will cover an Experimental or Investigational Service or Item approved by an External Appeal Agent certified by the State of New York. If the External Appeal Agent approves coverage of an Experimental or Investigational Service or Item 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 which are provided in such clinical trials. (For further information on external appeals, consult your Member Handbook).

3. Eye surgery to correct refractive error unless otherwise medically necessary.
4. Family Therapy.
5. Gender Change. Any service, item or treatment designed to alter physical characteristics of the Member to those of the opposite sex, and any other treatment, service, item, or studies related to sex transformation unless Medically Necessary.
6. Marriage counseling.
7. Personal comfort or convenience items that are not otherwise Medically Necessary.
8. Physical examinations or immunizations when required for employment, insurance, licensing, marriage, school, or travel that are not otherwise Medically Necessary.
9. Preferred Care will not cover any health service or item that we determine is not Medically Necessary. We will cover a service or item for which coverage had been denied for lack of Medical Necessity only if required by an External Appeal Agent certified by the State of New York. Coverage would then be provided only to the extent that such service or item is otherwise covered under the terms of this Certificate. (For further information on external appeals, please consult your Member Handbook.)

C. Limitations.

Medicare Carve-Out. We will not provide coverage for any Covered Benefit to the extent that is covered under Medicare or would be covered under Medicare (if you are entitled to Part A and eligible for Part B). In these circumstances Medicare will be considered the primary payer even if you have not elected to purchase Medicare Part B. PAC will not pay the portion of any claim which Medicare will cover if you have elected Part B or would have covered if you had elected Part B.

Part VI - Plan Administration and Forms

A. Premium Payment. The Premium charges will be determined by our Board of Directors. Premium charges are determined according to the laws and regulations of the State of New York.

1. Only when your Premium payment has been received are you entitled to health care services under this Certificate.
2. Premium payment is due on or before the first day of the billing period for which coverage is provided. A grace period of ten (10) days will be allowed.

B. Refusal to Accept Treatment. You may refuse treatment to the extent permitted by law, and have the right to be informed of the medical consequences should you choose that option.

C. Changes in Certificate or Premium.

1. We reserve the right to change this Certificate or change Premium rates in accordance with the laws and regulations of the State of New York upon at least thirty (30) days prior written notice to the Group, if the change is approved by the Superintendent of Insurance.
2. Changes to the Group Contract that affect your coverage under this Certificate, including the elimination of Riders that provide additional benefits, become effective on the effective date of the change.
3. Changes to this Certificate including, but not limited to changes to Covered Benefits, become effective on the effective date of the change.

D. Identification Cards. Identification Cards are issued for the purpose of identification only. Willfully or knowingly permitting another person to use your Identification Card to receive services constitutes fraud and could result in the termination of your PC and PAC Certificates and in civil and/or criminal legal action against you.

E. Authorization to Review or Obtain Health Care Records. By being a Member, you and your covered Dependents agree that any Health Professional, Hospital, Workers' Compensation Board, Plan or Other Insurance Carrier (including but, not limited to Indemnity, PPO, HMO, Workers' Compensation, No-Fault, Medicaid, & Medicare) is authorized to give us, upon request, all information and records (or copies) relating to your diagnosis or treatment necessary for treatment, payment and health care operations purposes.

F. Confidentiality of Health Care Records. We recognize your right to the confidentiality of your medical/health information received from any source, including physicians, Health Professionals, Hospitals and other health care providers incident to the physician-patient or hospital-patient relationship. By being a Member, you and your Dependents consent to our or our agents' use of your personal health information for treatment, payment and health care operations purposes. These purposes include, but are not limited to, disease prevention and management programs, coordination of health care treatment and benefits, utilization and claims review, quality assurance activities, complaint and dispute resolution processes, and accreditation. We will not otherwise disclose personally identifiable health information without the express consent of you or your Dependents unless required by federal or state law or regulation, or by court order. You can get a full copy of our Confidentiality Policy by contacting our Member Services Department.

G. Dispute Resolution. Although we strive to ensure that our Members receive the health care services they need as well as outstanding service, occasionally you may encounter a situation that's cause for concern. If the Member Services Department cannot satisfactorily respond to your concerns and you are in any way dissatisfied with our response to your issues or problems, you have a right to file a formal complaint. If you wish to appeal a previous decision associated with a denial of services or benefits, you have the right to access our dispute process. The timing of the dispute process is adjusted to reflect the urgency of the issue. Normally, complaints and disputes are investigated and responded to, in writing, within 30 business days of receipt of all necessary information. Details of the complete complaint and dispute process can be found in your Member Handbook and are also available by request from the Member Services Department.

Part VII - Termination of Coverage

A. Effective Dates

1. In the event that coverage terminates for any reason, all Covered Benefits will end on the date of termination.
2. Covered Benefits are not vested. This means that you do not have any rights to continue receiving Covered Benefits after coverage terminates.

B. Termination of Group Contract. When the Group Contract is terminated, coverage for all Members enrolled through the Group Contract terminates. The Group Contract may be terminated:

1. By the Group, for any reason, on its anniversary date, with fifteen (15) days written notice to us.
2. By us if the Group fails to pay the Premium for this Certificate when due, and if default continues after the grace period.
3. By us if the Group has committed fraud or made an intentional misrepresentation of material fact.
4. By us if no eligible employees work or reside in our Service Area.
5. By us if we terminate the entire class of contracts to which the Group Contract belongs, upon at least ninety (90) days prior notice of such termination.
6. By us or Group for any reason approved by the Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement provisions of the Act.

C. Termination of Member Coverage. A Member's coverage will automatically be terminated:

1. By us or Group for any reason approved by the Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement provisions of the Act.
2. By the Group if you no longer meet your Group's eligibility requirements.
3. By you during your Group's Open Enrollment.
4. On the date of the Employee's death, unless he or she has family coverage. In the case of family coverage, coverage automatically terminates as of the date to which the Premium was paid.
5. On the date of the divorce or annulment of an Employee's spouse in the event an Employee becomes divorced or his or her marriage is annulled.
6. By us for failure of your Group or you to make payment of Premiums or Copayments or other charges due us.
7. By us if you attempt or commit fraud against PAC or any of its affiliated companies in:
   a. Submitting a claim for benefit, or
   b. Completing the initial application or subsequent Dependent eligibility form, or
   c. Willfully or knowingly failing to notify us of a change in eligibility for any covered Member within the applicable timeframes, or
   d. Willfully or knowingly permitting another person to use your Identification Card.

   If you are terminated for fraud or attempted fraud you will not be eligible for any other Preferred Care or PAC coverage and we will not be responsible for payment of any claims that result from fraud. We may recover from you the cost of any services or items obtained by fraud.
8. By the Group, Member or us if you permanently reside or move outside of the Service Area for more than three (3) months, unless you work within the Service Area and have signed an Out-of-Area waiver. This provision does not apply to Dependent children.
9. By the Group, Employee or us for any Dependent Member who is no longer eligible for coverage as a Dependent.

Part VIII - Benefits for Total Disability After Termination

When your coverage under this Certificate ends, Covered Benefits stop. However, if you are totally disabled on the date the Group Contract terminates, or on the date your coverage under this Certificate terminates, and you have received services or care for the illness, condition, or injury which caused your total disability while you were covered under this Certificate, continued benefits may be available to you as follows.

A. **When You May Continue Benefits.** When you are totally disabled, you may continue benefits for Covered Benefits to treat the total disability, if one of the following applies.

1. **Termination of Employment, Eligibility, or Contract.** When your coverage under this Certificate ends because you are no longer actively employed; or you are no longer eligible for coverage under this Certificate; or the Group Contract terminates, then we will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within thirty-one (31) days from the date your coverage ends. The Hospital stay and/or surgery must be for treatment of the injury, sickness, or pregnancy causing the total disability.

2. **Termination of Active Employment.** If your coverage ends because you are no longer actively employed, we will provide benefits during a period of total disability for up to twelve (12) months from the date your coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability; unless coverage is provided for services in connection with the total disability under another group health plan.

3. **When Continued Benefits End.** The continued benefits will terminate when:

   a. You have used all the benefits available;

   b. We determine that you are no longer totally disabled; or

   c. Benefits are continued under -paragraph “Termination of Active Employment” above, and you reach the end of the twelve-month period from the date your coverage under this Certificate ends.

However, in no event will we pay for more care than you would have been entitled to receive if your coverage under this Certificate had not terminated. Also, this provision applies only when your coverage under this Certificate is terminated and not when this Certificate is changed according to Section “Plan Administration and Forms”, sub-section “Changes in Certificate or Premium”..

Part IX - Conversion Privilege

A. **Temporary Continuation**. 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 temporary continuation of 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 coverage under the New York State Insurance Law (State Law) as described below. Any continuation of coverage will terminate at the end of the period of continuation provided under COBRA or State Law.

Under State Law, if you lose coverage because of termination of your employment or loss of eligibility, you may continue coverage for yourself and your eligible dependents under the following conditions:

1. You are not entitled to Medicare and you aren't covered under or eligible for other group coverage which does not exclude or limit coverage for pre-existing conditions.
2. You request continued coverage within sixty (60) days after the later of the date your coverage ended or the date you were given notice of continuation by the Group.
3. If you want continuation because of a disability determination under Title II or Title XVI of the Social Security Act (SSA), you must notify the Group within sixty (60) days after a determination that you were disabled at the time your employment was terminated or at any time during the first sixty (60) days of continuation of coverage.
4. You pay the Premium when due. The Premium cannot exceed 102% of the current Group Premium.
5. Coverage terminates at the earliest of the following:
   a. Expiration of eighteen (18) calendar months after your coverage would have terminated because of termination of employment;
   b. The date to which Premiums are paid if you fail to make a timely payment;
   c. Expiration of thirty-six (36) calendar months after your 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;"
   d. Expiration of twenty-nine (29) calendar months after your coverage would have terminated because of termination of employment if the Employee is determined to have been disabled under the SSA at the time of termination of employment or at any time during the first sixty (60) days of continuation coverage. However, if the employee is no longer disabled, coverage will terminate at the later of the date in 'a' above, or the month that begins more than thirty-one (31) days after determination that the Employee is no longer disabled; or
   e. The date the Group no longer provides coverage to any of its employees.

B. **Right to a New Contract After Termination.** You have a right to convert to a new contract if your coverage under this Certificate terminates under certain circumstances.

1. Entitlement to a new contract. You may be entitled to purchase a contract with us as a direct payment subscriber if:
   a. The Group Contract is terminated for any reason and your employer has not replaced the coverage for the Group with similar and continuous coverage.
   b. Your coverage under this Certificate is terminated due to:
      (1) Termination of your coverage under the Group Contract because you are no longer a member of the Group,
      (2) Termination of your temporary continuation of coverage,
      (3) The death of the Employee,
      (4) Termination of your marriage, or
      (5) Your loss of eligibility as a Dependent.
2. The new contract. If you meet the eligibility requirements, you may purchase a Healthy New York individual health insurance contract from us. Otherwise, you may purchase one of our standardized direct payment HMO or HMO Point of Service contracts.

3. When to apply for a new contract. If you are entitled to purchase a new contract as described above, you must apply to us within forty-five (45) days of termination of your coverage under this Certificate. Should you not receive notification of your conversion privilege within fifteen (15) days after the date of termination, you must apply to us within ninety (90) days of termination of your coverage under this Certificate. You must also pay the first Premium of the new contract within the same forty-five (45) or ninety (90) day period.

C. **Supplementary Suspension, Continuation and Conversion Rights.** If you, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, and you enter active duty but the group contract holder does not voluntarily maintain your coverage, your coverage shall be suspended unless you elect, in writing to the group contract holder, within sixty (60) days of being ordered to active duty, to continue coverage under this Certificate for yourself and eligible dependents. Continued coverage shall not be subject to evidence of insurability. You must pay the required group rate premium in advance to the group contract holder, but not more frequently than once a month.

Supplementary continuation coverage shall not be available to any person who is, or could be, covered by Medicare or any other group coverage. Coverage available through the Federal government for active duty members of the armed forces shall not be considered group coverage for the purposes of this paragraph.

If you return to civilian status, you are reemployed or restored to participation in the group, after the period of continuation coverage, you (and your covered dependents if other than individual coverage applies), shall be entitled to resume coverage under this Certificate. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty provided that the applicable premium has been paid from that date. No exclusion or waiting period shall be imposed in connection with resumed coverage except regarding:

1. A condition that arose during the period of active duty and that has been determined by the secretary of veteran's affairs to be a condition incurred in the line of duty; or
2. A waiting period imposed that had not been completed prior to the period of suspension. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed eleven months.

If you return to civilian status, are not reemployed or restored to participation in the group, you shall have the right within thirty-one (31) days of the termination of active duty, or of discharge from hospitalization incident to active duty which continues for a period of not more than one year, to submit a written request for continuation to the group, or a request for conversion directly to us, as described elsewhere in this Certificate. The individual conversion policy shall be effective on the day after the end of the period of supplementary continuation. If other than individual coverage applies and you elect supplementary continuation or if coverage is suspended, the supplementary conversion right shall be available: to your spouse, if divorce or annulment of the marriage occurs during the period of active duty; if you die while on active duty, to your spouse and children covered under this Certificate, and to each child individually, upon attaining the limiting age of coverage under this Certificate.

The supplementary continuation and conversion rights described above do not apply to you, if this Certificate qualifies as an employer group health plan that is subject to the federal temporary continuation of coverage provisions of COBRA described above. The provisions relating to suspension of coverage shall apply to you even if the continuation and conversion rights do not apply.

Part X - Coordination of Benefits, Third Party Payments and Double Coverage

A. Non-duplication. We will provide you with full health care services within the limits of this Certificate. We will not duplicate benefits or provide you with greater benefits than the actual expenses incurred. Benefits under this Certificate will be reduced to the extent that they are available or that reimbursement is payable under any other Plan covering you whether or not a claim is made for the benefits.

B. Other Carrier Continuation of Coverage. We will not pay for Hospital care if you are a patient in a Hospital on the date your coverage under this Certificate becomes effective, to the extent coverage is provided under any other Plan.

C. Coordination of Benefits. It is not unusual that a person will be covered under two (2) Plans that provide similar coverage. If the service you receive is covered under both Plans, we will coordinate benefit payments with the other company. One company will provide its full benefit as a primary benefit. The other company will provide secondary benefits, if necessary, to the extent of its benefits. This prevents double payment and overpayment.

In order to determine which company is primary, these rules apply whether or not a claim is actually made under both Plans:

1. If the other Plan does not have a provision similar to this one, then it shall be primary.
2. If the person receiving the benefits is the Employee belonging to the Group through which, or to which one Plan was issued and is only covered as a Dependent on the other Plan, the Plan under which he or she is the Employee will be primary. However, if the person is a Medicare beneficiary, and, as a result of the rule provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is
   (a) Secondary to the Plan covering the person as a Dependent, and
   (b) Primary to the Plan covering the person as other than a Dependent (e.g. a retired employee).

   Then the order of benefits is reversed so that the Plan covering the person as an employee, Member, subscriber or retiree is secondary and the other Plan is primary
3. The Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) is primary to a Plan which covers that person (or that employee's Dependent) as a laid off or retired employee.
4. If two (2) or more Plans cover the person receiving care as a Dependent, then the Plan of the Employee whose birthday (month of day of birth) occurs earlier in the Calendar Year will be primary. If both parents have the same birthday, then the Plan that covered the parent longer is primary.
5. If the Dependent is the child of divorced or separated parents, then benefits for the child are determined in this order:
   a. First, the Plan of the parent with custody of the child;
   b. then, the Plan of the spouse of the parent with custody of the child;
   c. finally, the Plan of the parent not having custody of the child; and
   d. notwithstanding a, b, and c above, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any claim determination period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
6. If none of the above applies, then the Plan which has been in effect for the longest time shall be primary.

7. You are required to cooperate with us in the administration of this provision. If this Certificate requires that benefits be paid for by another Plan and you have failed to seek payment from that Plan, we will reduce the payments under this Certificate by the amount to which you are entitled from the Plan. In some cases we may ask you to sign documents or cooperate with us to seek payment from another Plan. You are required to cooperate in such cases.
8. None of the above rules as to coordination of benefits will serve as a barrier to you first receiving Covered Benefits under this Certificate.
9. None of the above coordination of benefits rules supersede Preferred Care rules regarding Referrals and Precertification of services if Preferred Care is the primary payer.

D. **Subrogation.** In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and we pay benefits as a result of that injury or illness, we will be subrogated and succeed to the right of recovery against the party responsible for your illness or injury and have a lien to the extent of the benefits we have paid. This means that we have the right, independently of you, to proceed against the party responsible for your injury or illness to recover the benefits we have paid.

E. **Duty to Cooperate with Us - Possible Penalties for Failure to Cooperate.** We will pay all expenses associated with a legal action initiated by us. However, if you fail to cooperate with us in proceeding against the party responsible for your illness or injury to recover the benefits we have paid and we are unable to recover such benefits, you must repay to us the amount of the benefits we have paid. We agree to invoke this subparagraph only when your illness or injury caused by a third party results in our expenditure on your behalf of an amount exceeding $500 under this coverage. We are also entitled to be reimbursed for the benefits we have paid from a settlement or a judgment you receive from the party responsible for your illness or injury when the settlement of judgment you receive specifically identifies or allocates monetary sums directly attributable to expenses for which we have paid benefits.

Part XI - Claims Procedures

A. Filing a Claim.

1. *Where to File*. You must provide written notice of your claim to PAC within twenty (20) days after you receive/obtain services under this Certificate, or as soon after as reasonably possible. Send your notice to: Preferred Assurance Company, Inc., 259 Monroe Avenue, Rochester, New York 14607. Include your name, address and Identification Number on your claim.
2. *Claim Forms*. After PAC receives your notice of claim, PAC will provide you with claim forms. If we fail to do so within fifteen (15) days after we receive your notice, you may send us your claim by including the following:
    a. Your name, address and Identification Number; and
    b. A copy of your itemized statement for health care services.
3. *How to File*. You must complete the claim forms and send or deliver them to the address above within ninety (90) days after you received Covered Benefits under this Certificate or as soon as reasonably possible. This is your "proof of loss." You may request additional claim forms by contacting the Member Services Department.
4. *Failure to Provide Proof*. Reimbursement for Covered Expenses may be denied or reduced if you do not provide PAC proof of loss within ninety (90) days, unless it was not reasonably possible for you to have given proof within that time. Then the proof must be furnished as soon as reasonably possible. You may not submit proof later than one year from the date you received the Covered Benefits.

    Alternatively, should you receive services from a non-participating provider who submits a claim to Preferred Care directly, they would follow the same procedures outlined above. You would be responsible to ensure they submit the claim in a timely manor. You would provide, in writing, permission for PAC to pay the provider of the health services directly. They may not submit proof of loss later than one year from the date they provided the Covered Benefits. Should they fail to submit the claim within the proper time frame you would be responsible for Covered Expenses.

B. Payment of Claims. All Covered Expenses for Covered Benefits under this Certificate shall be paid when PAC receives proof of loss. Covered Expenses will be paid to the Employee unless the Employee, or in the case of a Dependent, the custodial parent, asks PAC in writing to pay the provider of the health services directly.

Part XII - General Provisions

A. **Entire Contract.** The Group Contract, the Group's application, this Certificate, along with your PC Certificate, any Riders, your Enrollment Form, your identification card, and any amendments added now or in the future constitute the entire Contract between us, the Group, the Employees and enrolled Dependents. As of the effective date of this Certificate, all other agreements between the parties are superseded. By enrolling in PAC, the Member agrees to abide by the terms and rules as described in this Certificate.

B. **Form or Content of Plan.** No agent or representative of PAC, other than its President, is authorized to change this Certificate.

C. **Administration of Plan.** PAC may adopt reasonable policies, procedures and rules and interpretations to promote its orderly and efficient administration. These actions will not alter this Certificate.

D. **Assignment.** This Certificate is not assignable by the Group or by you without our written consent.

E. **Amendment.** We may amend this Certificate as provided in the Plan Administration and Forms section of this Certificate.

F. **Litigation for Payment.** You may not sue PAC for refusing to pay for services unless you start the suit within one (1) year from the date of denial of services.

G. **Legal Venue.** This Certificate is governed by the laws of the State of New York and any legal action must be brought and resolved in New York State.

H. **Notice.** When a notice is required under this Certificate, it may be mailed to: Preferred Assurance Company, 259 Monroe Avenue, Rochester, New York 14607, and to the Group and/or to you at the most recent address on file with us. You are required to inform us of any change of address in a timely manner.

I. **Clerical Error.** Clerical error, whether of the Group or PAC, in keeping any record pertaining to the coverage under this Certificate, will not invalidate the coverage otherwise validly in force or continue coverage otherwise validly terminated.

J. **Information.** Information as to how services may be obtained will be furnished to you after enrollment and may also be obtained at any time upon request to the Member Services Department.

K. **Subtitles.** The subtitles included in this Certificate are provided for the purpose of identification and convenience and are not part of the complete Certificate.

L. **PAC May Sell or Assign this Certificate to a Third Party.** Such occurrence shall not constitute a default on the part of PAC nor entitle you to avoid your responsibilities under this Certificate.