



HEALTH CARE CERTIFICATE

COMPREHENSIVE PLAN

Preferred Care is pleased to supply you this Health Care Certificate with Rochester Area Health Maintenance Organization, Inc. This Certificate describes the health benefits provided for you by Preferred Care, located at 259 Monroe Avenue, Rochester, New York 14607. We can be reached by phone at (585) 325-3113 or (800) 950-3224. Members with a speech or hearing impairment and access to TTY equipment may call (585) 325-2629 or (800) 252-2452.

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

By enrolling in Preferred Care 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 Preferred Care.

Preferred Care is a health maintenance organization and all health care services must be provided by, or arranged and authorized in advance by your Primary Care Physician (PCP) and Preferred Care, **except** for Emergency Services as described in the Services and Benefits section of this Certificate. (In addition to a PCP, an obstetrician/gynecologist can also provide or arrange and authorize health care services with Preferred Care for our female Members.)

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.

PREFERRED CARE

A handwritten signature in cursive script, appearing to read "David W. Miller".

President

A FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATION

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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 the Explanation of Copayments, 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 Preferred Care coverage.
- D. Coinsurance** means the percentage of Covered Expenses that are paid by the Member. Coinsurance amounts are described on the Explanation of Copayments included with 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. Copayment** (or Copay) means a fixed dollar amount of Covered Expenses paid by you directly to the health care provider at the time services or items are received. Copayments are described on the Explanation of Copayments included with this Certificate. Copayments may be changed by us from time to time.
- G. Cosmetic** means a service or item whose purpose is to alter one's appearance without being Medically Necessary.
- H. Covered Benefits** means the health care services and items for which coverage is provided under this Certificate.
- I. Covered Expenses** 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 which are less than or equal to our maximum allowable fees in effect at the time the service is rendered or the item is purchased. (Note: A Hospital may issue billing statements to Members that show amounts that are different than the Covered Expense for a Covered Benefit. In certain situations, these charges do not represent the amount payable under this Certificate. The Covered Expense and Coinsurance amount, if any, is determined by the agreement between the Participating Provider and Preferred Care.).
- J. 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.
- 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 this 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 this 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 that 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 Preferred Care.
- R. Group Contract** means the agreement between the Group and Preferred Care 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 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. The services provided by a Home Health Agency must be authorized by your Primary Care Physician and Preferred Care.
- V. 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 rehabilitary care.
- W. Maternity Care** includes care required by pregnancy, childbirth, abortions and miscarriages.
- X. Medical Director** means a physician designated by Preferred Care to monitor appropriate use of health services and quality of care.
- Y. 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 your Primary Care Physician or a Health Professional, and approved by us. 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.
- Z. Member** means any Employee or enrolled Dependent entitled to Covered Benefits under this Certificate.

- AA. 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.
- BB. 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.
- CC. 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).
- DD. Out-of-Network Services** means those services provided by a non-Participating Provider. Coverage for Out-of-Network Services is limited to Emergency Services and services that are arranged and authorized in advance by the Primary Care Physician and us.
- 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. Plan Physician** means a Primary Care Physician or Specialist with whom Preferred Care has an agreement.
- II. Pre-Certification** means that, in order for certain services or items to be a Covered Benefit, a Participating Provider must obtain certification or authorization from Preferred Care.
- JJ. Premium** means the periodic payment (usually monthly) made to us on your behalf that entitles you to the benefits in this Certificate.
- KK. Primary Care Physician (PCP)** means an internist, general or family practice physician, or pediatrician who is chosen by you from our list of Participating Providers. Each Member must choose a PCP who is responsible to provide or arrange for all Covered Benefits. (In addition to a PCP, female Members may also select an obstetrician/gynecologist from our list who can also provide or arrange for Covered Benefits.).
- LL. Prior Justification** is a subset of Pre-Certification that involves clinical review and authorization, by the Preferred Care Medical Director or designee, of requests for certain services or items made by a Participating Provider. Authorization must be obtained before the service or item is received for it to be a Covered Benefit.
- MM. 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 within the Service Area, and in accordance with our policies and procedures.
- NN. 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.
- OO. Referral** means the recommendation of your Primary Care Physician or other Plan Physician for you to be evaluated and/or treated by a different physician, specialist, or service provider. Most services require a Referral.
- PP. 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.

- QQ. Service Area** refers to the geographic area that Preferred Care is authorized to sell the HMO Group Contract to Policyholders. The Service Area may be expanded with the approval of the appropriate Federal and State agencies.
- RR. 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.
- SS. 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).
- TT. Specialist** means a physician or other Health Professional who provides services on an authorized referral basis or in an emergency. All Referrals to Specialists must be made by the Primary Care Physician with our prior approval.
- UU. Urgent Care Center** means a free-standing facility or an Urgent Care Department within a Hospital that provides care to patients requiring Urgent Services.
- VV. Urgent Services** are services for conditions which, in the judgment of our Medical Director, are not a medical emergency, but which require prompt treatment to prevent serious deterioration of your health.
- WW. We, Our or Us** refers to Preferred Care.
- XX. You or Your** refers to you (Employee/Member) and your eligible enrolled Dependent(s) (Member(s)).

Part II - Eligibility, Enrollment and Effective Date of Coverage

A. Eligibility.

1. *Employee.* To be eligible to enroll as an Employee you must:
 - a. Live or work in the Service Area; and
 - b. Be a bona fide employee of the Group entitled to participate in the health care benefit program arranged by the Group, or be entitled to coverage under a trust agreement or through membership in an association; and
 - c. Satisfy any probationary or waiting period requirements established by the Group and meet all eligibility requirements of the Group.
2. *Dependents.* To be eligible to enroll as a Dependent the person must:
 - a. Meet all Dependent eligibility requirements established by the Group; and
 - b. Be the Employee's lawful spouse who lives either in the Service Area or with the Employee; or
 - c. Be an unmarried child who is:
 - (1) A child as defined below; and
 - (2) Under the age of twenty-six (26); and
 - (3) Not eligible for health insurance through his or her employer; or
 - (4) Who has reached the age at which dependent coverage would otherwise terminate if they are unable to self-sustain employment because of any of the following reasons:
 - (a) Mental illness as defined in the New York State Mental Hygiene Law; or
 - (b) Developmental disability as defined in the New York State Mental Hygiene Law; or
 - (c) Mental retardation as defined in the New York State Mental Hygiene Law; or
 - (d) A physical handicap; and
 - (e) All of the following criteria are met:
 - The condition must have occurred before the child reached the age at which coverage would otherwise terminate; and
 - You have filed a "Handicapped Dependent Application" (available from our Member Services Department) upon enrollment or within sixty (60) days after the date the dependent coverage would otherwise terminate; and
 - The child must be chiefly dependent upon the Employee for support and maintenance; and
 - The disability must be certified by a physician (who must be a Participating Provider if the child is already a Member of Preferred Care) in a form we determine. Such certification must be approved by our Medical Director or designee.
 - d. The following are considered children:
 - (1) Natural children;
 - (2) Newborn children;
 - (3) Legally adopted children;
 - (4) Children whom you propose to adopt and who are dependent upon you during the waiting period prior to adoption;
 - (5) Newly born infants adopted by you if:
 - (a) You take physical custody of the infant upon the infant's release from the Hospital and you file a petition pursuant to New York State Domestic Relations Law, Section 115-c within thirty (30) days of birth; and
 - (b) Provided that no notice of revocation to the adoption has been filed pursuant to New York State Domestic Relations Law, Section 115-b; and
 - (c) Consent to the adoption has not been revoked.There will be no coverage of the initial Hospital stay where a natural parent has insurance coverage available for the infant's care;
 - (6) Children for whom you are the legal guardian and who are chiefly dependent upon you for support and maintenance;
 - (7) Stepchildren who are dependent upon you for support and maintenance.
 - (8) Natural children of your Dependent if his /her children meet the eligibility criteria described above. Your Dependent's child may remain covered only while his/her parent (your child)

is covered as a Dependent. Once your child is no longer a Dependent, his/her child will also no longer be a Dependent.

- (9) If you have family coverage this contract provides coverage for dependent students who take a medical leave of absence from school due to illness for a period of twelve (12) months from the last day of attendance at school, provided, however, that coverage of a dependent student would not be beyond that age at which coverage would otherwise terminate. Preferred Care may require that the Medical Necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.

Please note that we have the right to verify whether a child continues to qualify as a dependent under this section of the Certificate.

3. *Medicare Eligibility.* Unless your Employer's eligibility policy states otherwise, if you become eligible to enroll in Medicare and are retired or become permanently disabled, coverage under this Certificate will cease, you will be notified and may enroll in Preferred Care's Medicare Program. This Certificate will not terminate if the following conditions are met:
 - a. If you are an active employee of the Group through which this Certificate is issued; or
 - b. If you are the spouse of an active employee of the Group through which this Certificate is issued.

B. Enrollment.

Apart from anything else in this section, you will not be eligible to re-enroll in any Preferred Care Plan if your coverage has been terminated under the provisions described in the Termination of Coverage section of this Certificate, sub-section Termination of Member Coverage.

1. *Group Open Enrollment.* As an eligible Employee of the Group, you are entitled to enroll yourself and your eligible dependents during Group Open Enrollment Periods. All persons included for coverage must be listed on the Enrollment Form provided. No proof of insurability will be required.
2. *Newly Eligible Employees and Dependents.* Employees may become eligible to enroll at a time that does not fall within the Group Open Enrollment Period. When this occurs, you may enroll yourself and your eligible dependents within thirty (30) days of becoming eligible. If someone later becomes eligible as a dependent, you may enroll that person by completing and submitting to us a signed Enrollment Form within thirty (30) days of becoming eligible (e.g. from the date of adoption, marriage, etc.). No proof of insurability will be required. However, proof of eligibility may be required.

Newborn children will be covered from the date of birth when added within thirty (30) days. If we do not receive the completed Enrollment Form within thirty (30) days of the birth, coverage of the newborn will become effective the first of the month following the receipt of the completed Enrollment Form.

3. *Limitation.* Except for newborns, who will be covered from the first of the month following the date that notice of birth is given, persons initially or newly eligible for enrollment who do not enroll within thirty (30) days of eligibility may enroll only during the next Group Open Enrollment Period.
4. *Notice of Ineligibility.* It is your responsibility to notify us of any changes affecting your eligibility or the eligibility of your dependents within thirty (30) days of the change. This includes, but is not limited to, loss of eligibility due to divorce, death, marriage, employment, loss of full time student status, or age. Failure to notify us of ineligibility may constitute fraud and could result in the termination of your Preferred Care Certificate and in civil and/or criminal legal action against you.

C. Effective Date of Coverage.

After we receive your completed Enrollment Form, including selection of a Primary Care Physician, and the appropriate arrangements for payment of Premium are made, your coverage under this Certificate will begin on the earliest of the following dates:

1. *Initial Enrollment and Open Enrollment.* Coverage will begin on the date agreed upon by the Group and Preferred Care.
2. *Newly Eligible Employees and their Dependents.* Coverage will begin according to the Group's eligibility policy.
3. *Newly Eligible Dependents.* Coverage will begin as of the date of the event such as marriage, adoption, or guardianship, but ONLY if the completed Enrollment Form is received within thirty (30) days of the event. Newborn children will be covered from the date of birth when added within thirty (30) days. If we do not receive the completed Enrollment Form within thirty (30) days of the birth, coverage of the newborn will become effective the first of the month following the receipt of the completed Enrollment Form.
4. *The Effective Date of Coverage* as noted in 2 and 3 above may be changed by agreement of the Group and us.
5. *Delivery of Certificate.* We will provide you with a Certificate and other Member materials after enrollment.

D. Renewal Date.

This Certificate renews January 1st of each year

Part III - Services and Benefits

General Provisions.

1. You are eligible to receive the following medical, surgical, diagnostic, therapeutic, and preventive services and items generally and customarily provided in the Service Area. As a Member of a health maintenance organization, you and your Primary Care Physician must work together. Your Primary Care Physician has accepted the responsibility to provide, coordinate, and arrange your health care services.
2. Preferred Care 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 Member Handbook.)
3. Except in an emergency, as described in the Services and Benefits section of this Certificate, ONLY services which are performed, prescribed, directed or authorized by your Primary Care Physician and approved in advance by the Preferred Care Medical Director or designee are Covered Benefits. This is true even if a service is listed as a Covered Benefit.
4. Except in an emergency, as described in the Services and Benefits section of this Certificate, Out-of-Network Services are not covered. The only exception is if the service is Medically Necessary to be performed Out-of-Network (e.g. when services are not available in-network) and when Prior Justified.
5. Except in an emergency, as described in the Services and Benefits section of this Certificate, services must be received from a Participating Provider. Please remember that Preferred Care may not contract with a particular facility or provider for all services that the facility or provider is licensed to provide (e.g. Preferred Care may contract with a Hospital, but not with its associated mental health clinic). Similar types of facilities and providers may not be contracted to provide the same services. Preferred Care often contracts with various facilities and providers to provide specific services (e.g. facility may offer many services, but be contracted only for those that cannot be supplied by other in-plan providers). Participating Providers who render a service that are not contracted to provide or for which they did not obtain the proper authorization cannot bill you unless you acknowledge in writing that you will pay for that service yourself. **Please read and understand all such acknowledgements (commonly called waivers) prior to signing.**
6. Some services require you to make payment to the provider in the form of either a Copayment or Coinsurance amount. Copayments and Coinsurance must be paid at the time the services are received. Copayment and Coinsurance amounts are included in the attached Explanation of Copayments.

A. Doctors and Other Health Professional Services.

You must select a Primary Care Physician (PCP) who will provide, arrange, and coordinate all your health care needs. Female Members may, in addition, select an OB/GYN to manage their care. Coverage is provided for:

1. *Office Visits.* Services for the prevention, diagnosis, and treatment of illness or injury when provided in the medical office of the Primary Care Physician or an authorized Specialist.
2. *Hospital Services.* Services of Primary Care Physicians and other authorized Health Professionals for diagnosis, treatment, and consultation are provided while you are hospitalized for authorized services and/or Emergency Services as described in this Certificate. Services include a second surgical opinion on the need for surgery by a qualified Plan Physician, either in the Hospital or in the medical office of the Plan Physician.

3. *Outpatient Services.* Services for the diagnosis and treatment of illness or injury in an outpatient setting by your Primary Care Physician or other authorized 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 Primary Care Physician or authorized Specialist when indicated by the nature of the illness or injury.
5. *Acupuncture Services.* Coverage is provided for acupuncture services which are Medically Necessary to treat neuromusculoskeletal pain resulting from an injury or illness, or for the treatment of asthma, allergies, nausea and/or vomiting up to a maximum of ten (10) visits per calendar year. Acupuncture services must be Pre-Certified and provided by a licensed acupuncturist who is a Participating Provider.
6. *Allergy Care.* Allergy testing, evaluation, serum and injections when provided by your Primary Care Physician or an authorized Specialist.
7. *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 cover only Medically Necessary chiropractic care. Chiropractic services must be Pre-Certified and provided by a chiropractor who is a Participating Provider.
8. *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 Plan Physician and the patient to be appropriate. Services must be Pre-Certified and arranged by a Plan Physician.
9. *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. Second opinions for the treatment of cancer can be obtained from either a Participating or non-Participating Provider and must be Pre-Certified and arranged by a Plan Physician. A second opinion for cancer will be at no additional cost to you.

B. Emergency Care, Urgent 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 with 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. *Urgent Care.* Coverage is provided for Urgent Services as defined in the Definition section of this Certificate if the Primary Care Physician determines Urgent Care is required but cannot see the Member. The Primary Care Physician can refer the Member to the nearest participating Urgent Care Center for treatment. These services are covered only if the Primary Care Physician referred the Member to the Urgent Care Center.

If you require Urgent Care while Out-of-Network, you must **first** call your Primary Care Physician. Urgent Care rendered by non-Participating Providers and/or while Out-of-Network **must** be Pre-Certified by your Primary Care Physician in advance of your receiving the services in order to be covered.

3. *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.

C. Health Maintenance and Preventive Services.

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

1. *Adult Physicals.* Periodic physicals for adults, based upon generally accepted guidelines relative to age, sex, and medical history.
2. *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
3. *Gynecological Exams.* Biannual (twice a year) gynecological examinations and pap smears.
4. *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.
5. *Mammography Screening.* Mammography screening for occult breast disease is covered under the following conditions:
 - a. On the recommendation of a Plan Physician, a mammogram at any age for Members having a prior history of breast cancer or whose mother or sister has 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.
6. *Prostate Screening.* Prostate screening for occult prostate disease is covered under the following conditions:
 - a. On the recommendation of a Plan Provider, standard diagnostic testing including, but not limited to, a digital rectal exam and Prostate-specific antigen (PSA) test at any age for Members 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.
7. *Routine Eye Exams.* A routine eye exam (including refraction), once every Calendar Year.
8. *Well-Child Visits.* Well child visits through age eighteen (18), according to American Academy of Pediatrics guidelines. We will cover services typically provided in conjunction with a well child visit, including at least: a complete medical history, a complete physical exam, developmental assessments, anticipatory guidance, laboratory tests performed in the practitioner's office or in a clinical laboratory and/or other services ordered at the time of the well child visit.

D. Home Health Services, Hospice Care, Acute Care and Home Infusion Services.

1. *Home Health Services.* Coverage is provided for in-home services by Health Professionals only when a stay in a Hospital or Skilled Nursing Facility would otherwise have been required. 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.
2. *Hospice Care.* Terminally ill Members are eligible for hospice care. A Member is considered terminally ill if the Primary Care Physician has certified the Member as having a life expectancy of six (6) months or less. All care must be provided by a certified hospice organization and must be Pre-Certified. Coverage is provided for the following services:
 - a. Inpatient care (in a hospice, Skilled Nursing Facility, or a Hospital), and outpatient care as determined by your Primary Care Physician and approved by us.
 - b. Drugs and medical supplies provided by the Hospital, Skilled Nursing Facility or hospice.
 - c. Up to five (5) visits for bereavement counseling for Members who are family members before or after the death of the Member.
3. *Acute Care.* Coverage is provided for acute care services at an acute care facility licensed pursuant to article twenty- eight of the Public Health Law and specializing in the treatment of terminally ill patients if:
 - a. The Member is diagnosed with advanced cancer (with no hope of reversal of the primary disease and fewer than sixty (60) days to live, as certified by the Member's attending health care practitioner); and
 - b. The Member's attending health care practitioner, in consultation with the medical director of the facility, determines that the Member's care would appropriately be provided by such a facility.
4. *Home Infusion Services.* Coverage is provided for home infusion services and Medically Necessary Durable Medical Equipment required for the administration of the infused drug(s) when provided by a Participating Provider and referred by a Plan Physician.

E. Hospital Services and Skilled Services.

All Hospital services must be Pre-Certified and arranged by your Primary Care Physician, except as described under the Services and Benefits section of this Certificate.

1. *Inpatient Services.* Coverage is provided for the following inpatient services when provided, arranged or authorized by a Plan Physician:
 - a. Semi-private room and board, with no limit to number of days, except for mental health inpatient services, in some circumstances, and 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 Plan Physician in consultation with the Member.
 - b. Private rooms are covered only when Medically Necessary, authorized by a Plan Physician, and approved by Preferred Care.
 - 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. Anesthesia and 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. Blood and blood plasma and their administration.
 - j. Treatment of physical complications of mastectomy, including lymphedemas.
2. *Outpatient Services.* Coverage for the following services through a Hospital outpatient department is provided when referred (and, in some cases, Pre-Certified) by a Plan Physician:
 - a. Radiation therapy, chemotherapy and dialysis.
 - b. Diagnostic tests and procedures.
 - c. Short-term rehabilitation services meeting the criteria for Rehabilitation Services as described in the Services and Benefits section of this Certificate.
 - d. Outpatient surgery which is Pre-Certified by a Plan Physician.
 3. *Skilled Services.* Coverage is provided for the following inpatient semi-private Skilled Services and accommodations when Pre-Certified by a Plan Physician.
 - a. Skilled Services in a Skilled Nursing Facility or in a Hospital, provided the Skilled Services are temporary in nature. Skilled Rehabilitation services must lead to rehabilitation and increased ability to function within a reasonable period of time.
 - b. If you remain in a Skilled Nursing Facility or Hospital at a skilled level of care after discharge is ordered or after the maximum benefit period is reached, you will be responsible for all associated costs for the services.
 - c. Skilled Services are limited to one hundred twenty (120) days per Member per Calendar Year and three hundred sixty (360) days per Member per lifetime.
 - d. Care in a Skilled Nursing Facility that does not meet the criteria for Skilled Services is considered Custodial or domiciliary care. Such care is not a Covered Benefit.

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

Coverage is provided for the following services performed in an outpatient setting, as ordered by a Plan Physician:

1. *Laboratory services.* Laboratory 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
 - a. Computerized axial tomography scan (CT scans), Computerized tomographic angiography (CT angiography), Magnetic resonance imaging (MRI), Magnetic resonance angiography (MRA) and Positron emission tomography (PET scans).
 - b. Other diagnostic radiological procedures, including, but not limited to, x-ray examinations, fluoroscopy, and ultrasounds.
3. *Mammography.* Please see the Health Maintenance and Preventive Services section of this Certificate for information regarding covered mammograms.
4. *Bone Mineral Density Measurements or Tests.* Please see the Health Maintenance and Preventive Services section of this Certificate for information regarding covered Bone Mineral Density Measurements.

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 (including the services of a midwife) related to the delivery; and special procedures as determined by a Plan Physician and approved by Preferred Care. 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 care 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 the 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 care 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 authorized by a Plan Physician and 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.

H. Mental Health Services and Chemical Abuse / Chemical Dependence Services.

Coverage is provided for Mental Health Services and Chemical Abuse / Chemical Dependence services. You, your designee, or your Primary Care Provider must call us at (585) 327-2477 or toll free at 1(800) 836-1430 before receiving services, except when seeking emergency services, to receive authorization for coverage.

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.

Coverage is provided for the chemical abuse / chemical dependence services described below. You must call us at (585) 327-2477 or toll free at 1(800) 836-1430 before receiving services to receive authorization for coverage.

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 Provider.

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 Members, who are family members, for family therapy related to the family member's chemical abuse / chemical dependence. Coverage is not provided for outpatient services that consist primarily of participation in programs of a social, recreational, or companionship nature.

I. Rehabilitation Services.

1. *Rehabilitation Therapy.* Coverage is provided for outpatient speech therapy, physical therapy, and occupational therapy when prescribed by a Plan Physician of an appropriate specialty. Therapy is limited to a combined forty-five (45) visits per Calendar Year for treatment of conditions which are subject to significant clinical improvement within a reasonable period of time.

Rehabilitation therapy is therapy that results in significant clinical improvement, while maintenance therapy for chronic conditions does not result in significant clinical improvement and is not a Covered Benefit. Speech therapy and services associated with a learning disability are not covered if such therapy or services are available through the school district according to New York State Public Health Law and/or the Federal Individuals with Disabilities Education Act (IDEA).

2. *Developmental Delay.* Coverage is provided for speech therapy services for children with developmental delay through age three (3) subject to the limitations noted in paragraph 1 above.
3. *Cardiac Rehabilitation.* Coverage is provided for Phase II cardiac rehabilitation up to a maximum of thirty-six (36) visits on an outpatient basis when prescribed by a Plan Physician of an appropriate specialty.

J. 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 Participating Provider diagnoses a significant change in your symptoms or conditions necessitating changes in self-management, or where re-education or refresher education is necessary. Professional Services must be provided or Pre-Certified by a Participating Provider or Plan Physician. 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 and up to a ninety (90) day supply through mail order.

2. *HealthDollars.*

Benefits are provided up to the maximum noted on the attached Explanation of Copayments. HealthDollars may be used to offset the cost of participating programs. Participating programs may include programs such as fitness and exercise programs, recreation programs, massage therapy, health and wellness classes, water safety, and first aid classes.

3. *Medical Treatment of Obesity.*

Coverage is provided for participation in a Participating multidisciplinary weight management program for chronically obese members whose lives are endangered due to excessive weight. A multidisciplinary weight management program must include nutritional counseling, exercise instruction and behavior modification components. Services must be Prior Justified by your Primary Care Physician. Services are limited to one (1) program per Member per lifetime.

4. *Private Duty Nursing Services*

Short-term Private Duty Nursing services are covered when Prior-Justified by a Plan Physician.

5. *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 is provided for external breast prosthetics only.
- 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.
- d. *Hearing Aids.* Benefits are provided for hearing aids for children through age 18 up to a maximum benefit of \$600 every three (3) years.

Coverage is provided only for the basic prosthetic and any Medically Necessary special features prescribed by your Plan Physician and approved by Preferred Care. Prosthetics must be provided by a supplier that is a Participating Provider and has received authorization from Preferred Care. 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.

6. *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 Care benefit.

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

We will not provide coverage for dental care or treatment including, but not limited to, general dental services and those 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 except for dental care and treatment for the following procedures when provided in an inpatient or outpatient setting when Pre-Certified by a Plan Physician or when provided in an emergency setting:

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.

L. Alternative Benefits.

We may pay for, on an extra-contractual basis, services furnished by a Participating Provider pursuant to an alternative treatment plan of ours if your condition would otherwise require Hospitalization.

We may provide such alternative benefits if and only for so long as:

1. You want to receive the alternative benefits, and
2. We determine, among other things, that the alternative services are Medically Necessary, safe, cost-effective, and feasible. The total amount paid for such services will not exceed the total benefits to which the Member would otherwise be entitled under this Certificate in the absence of alternative benefits.

Services paid under this section are not Covered Benefits. If we elect to pay for alternative benefits in one instance, it will not obligate us to provide the same or similar payments for you or any other Member in any other instance. Payments for alternative benefits shall not be construed as a waiver of our right to administer this Certificate thereafter in strict accordance with its expressed terms.

Alternative benefits you receive are in lieu of the Covered Benefits we would normally provide to you under this Certificate for the treatment of your condition. Therefore, we may require you to waive certain Covered Benefits in order to receive alternative benefits. If you resume the use of Covered Benefits after receiving alternative benefits, the Covered Benefits remaining available to you will be reduced in a manner that appropriately reflects the alternative benefits you used.

Part IV - 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. Benefits provided under any employer's liability or occupational disease law.
2. Chemical abuse / chemical dependence services, except as described in the Services and Benefits section of this Certificate.
3. Contraceptives.
4. Cosmetic. 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.
5. 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.
6. Durable Medical Equipment (DME), except as described in the Services and Benefits section of this Certificate.
7. External Prosthetics, other than external breast prosthetics.
8. Eyeglasses and contact lenses and examination for the prescription and fitting of eyeglasses, except as described in the Services and Benefits section of this Certificate.
9. Family Member. Services performed by a member of the Member's immediate family.
10. 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.
11. Government Hospital. Treatment provided in a government Hospital, except as described in the Services and Benefits section of this Certificate, sub-section Emergency Care, Urgent Care and Pre-Hospital Emergency Services.
12. Government Programs. Benefits for which coverage is available to you under any government program, except Medicaid.
13. Hearing aids, hearing exams, and procedures for prescription or fitting of hearing aids, except as described in the Services and Benefits section of this Certificate.
14. Hospital Employees. Services rendered and separately billed by employees of hospitals, laboratories or other institutions.
15. Medical Supplies, except as described in the Services and Benefits section of this Certificate.
16. 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.
17. 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.
18. Non-covered Services. Any service, care, supply or equipment which is not specifically covered under the Services and Benefits section of this Certificate.
19. Orthotics (including Custom-made foot orthotics).
20. Payment for services that would normally be provided without charge.
21. Personal growth and/or educational requirements in conjunction with the mental health and chemical abuse / chemical dependence benefits.

22. Prescribed drugs and medications, except as provided while confined as an inpatient or provided for diabetic care, or as described in the Services and Benefits section of this Certificate.
23. 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.
24. Rest cures.
25. 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.
26. Transportation, except as described under the Services and Benefits section of this Certificate.
27. 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.
28. 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.
29. Workers' Compensation. Benefits to the extent that they were provided under the Workers' Compensation Law.

B. Medical Necessity Exclusions.

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

1. Custodial Care, except as described in the "Home Health Services, Hospice Care, Acute Care and Home Infusion" section of this Certificate.
2. Embryonic transfer and related services, and any service, treatment or service to reverse voluntary sterilization.
3. 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 which approval may have been granted but the service or item has been determined by the medical community in 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 Investigational 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).

4. Eye surgery to correct refractive error.
5. Family Therapy.
6. 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.
7. Marriage counseling.
8. Personal comfort or convenience items that are not otherwise Medically Necessary.
9. Physical examinations or immunizations when required for employment, insurance, licensing, marriage, school, or travel that are not otherwise Medically Necessary.
10. Speech therapy and any other services which are educational in nature, except as provided in the Services and Benefits section of this Certificate.

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. Preferred Care 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 V - Plan Administration and Forms

- A. Relationship between Preferred Care and Participating Providers.** The relationship between Preferred Care and Participating Providers is that of an independent contractor relationship. Participating Providers are not agents or employees of Preferred Care, nor is Preferred Care or any of its employees, an employee or agent of Participating Providers. We will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care through any Participating Provider.
- B. Patient/Provider Relationship.** Plan Physicians maintain a provider-patient relationship with you and are solely responsible to you for all health services. If you are unable to establish an acceptable patient-provider relationship you may request another provider, and likewise providers may request that you be transferred to another provider.
- C. 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. Premium payment is due on or before the first day of the billing period for which coverage is provided.
 2. Only when your Premium payment has been received are you entitled to health care services under this Certificate. A grace period of ten (10) days will be allowed.
- D. 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.
- E. 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.
- F. 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 Preferred Care Certificate and in civil and/or criminal legal action against you.
- G. Authorization to Review or Obtain Health Care Records.** By being a Member, you and your Dependents agree that any Health Professional, Hospital, Workers' Compensation Board, Plan or Other insurance carrier (including but, not limited to Indemnity, preferred provider organization (PPO), health maintenance organization (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.
- H. 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.

- I. **How to File a Claim.** Except for required Copayments, you should not have to make payments to Participating Providers because we will pay them directly. If, however, authorized services are received from non-Participating Providers, we reserve the right to pay either you or the provider. If you have paid for Covered Benefits, you may be reimbursed if:
 1. You provide us with an itemized bill including the diagnosis, date and place of service, a description, and the charge for each service rendered. The bill must clearly indicate the provider's name, address, phone number, and Tax Identification Number.
 2. You make the request for reimbursement within six (6) months of the date of service, or as soon as reasonably possible if you are incapacitated or otherwise unable to file a claim. Requests should be made to:

Preferred Care, Attn: Claims
259 Monroe Avenue
Rochester, New York 14607.

Part VI - 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, live 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 Preferred Care 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 Preferred Care 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. 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.
4. 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.
5. By you during your Group's Open Enrollment.
6. By us for failure to of your Group or you to make payment of Premiums or Copayments or other charges due us or Participating Providers.
7. By us if you attempt or commit fraud 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 Preferred Care of a change in eligibility for any Member within the timeframes laid out in the Eligibility section of this Certificate; 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 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 do not either work or live within the Service Area for any period longer than three (3) months. This provision does not apply to Dependent children.
9. By the Group, Employee or us for any Dependent who is no longer eligible for coverage as a dependent.

Part VII - Benefits for Total Disability After Termination

If you are totally disabled on the date your coverage under this Certificate terminates, we will continue to provide coverage, but only for a condition causing total disability that began prior to the date of termination, and only until one of the following occurs:

1. You are no longer totally disabled; or
2. The maximum benefit, if any, has been reached; or
3. A period of twelve (12) months from the date of termination has elapsed

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 the sub-section of the Certificate entitled Changes in Certificate Premium.

Part VIII - 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 then 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 IX - 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. If the other Plan doesn't have this rule, but instead has a rule based on the gender of a parent and, as a result, the Plans do not agree on which shall be primary, then the gender rule in the other Plan will determine the order of benefits.
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 Pre-Certification of services if Preferred Care is the primary payer of the claim.

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.

Duty to Cooperate with Us. Possible Penalties for Failure to Cooperate. Under certain circumstances, 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. This applies when:

1. The settlement or judgment you receive from the party responsible for your illness or injury specifically identifies or allocates monetary sums directly attributable to expenses for which we have paid benefits; or
2. You fail to cooperate with us in proceeding against the party responsible for your illness or injury to recover the benefits we have paid. We will pay all expenses associated with a legal action initiated by us. However, if you fail to cooperate with us, you must repay to us the amount of the benefits we have paid.

We agree to invoke subparagraph 2 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.

Part X - General Provisions

- A. Entire Contract.** The Group Contract, the Group's application this Certificate, along with the Explanation of Copayments, 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 Preferred Care, 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 Preferred Care, other than its President, is authorized to change this Certificate.
- C. Administration of Plan.** Preferred Care 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 Preferred Care for refusing to pay for services unless you start the suit within one (1) year from the date of denial.
- 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 Care, 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 Preferred Care, 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.