HEALTHY NEW YORK
INDIVIDUAL SUBSCRIBER CONTRACT

The Rochester Area Health Maintenance Organization, Inc., doing business as Preferred Care, is pleased to supply you this Healthy New York Contract. It entitles you and your covered dependents, if any, to the benefits set forth in the Contract. Coverage begins on the effective date stated on your identification card. This Contract will continue unless it is terminated for any of the reasons described in the Contract. Preferred Care is located at 259 Monroe Avenue, Rochester, New York 14607, You may contact us at (585) 325-3113 or (800) 950-3224.TTY users may call (585) 325-2629 or (800) 662-1220.

Notice of 10-Day Right to Examine Contract

You have the right to return this Contract. Examine it carefully. You may return it and ask us to cancel it. Your request must be made in writing within ten (10) days of the date that you receive this Contract. We will refund any premium you paid. If you return this contract, we will not provide you with any benefits.

IMPORTANT NOTICE:

Except as stated in this Contract, all services must be provided, arranged, or authorized by your Primary Care Physician ("PCP"). You must contact your PCP in advance in order to receive benefits, except for emergency care and for certain obstetric and gynecological care.

PREFERRED CARE

President

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SECTION ONE - INTRODUCTION

1. **Healthy New York Program.** This Contract is being issued pursuant to a special New York State program designed to make health insurance available to uninsured employees whose employers do not provide group health insurance coverage. You may choose between a high deductible health plan or a standard health plan upon initial enrollment and at the time of annual recertification. We will enroll you in the Healthy New York Program if you meet the eligibility requirements established by New York State and you will be entitled to the health care services described in this Contract. Each year, you must submit to us a certification of continued eligibility and necessary supporting documentation at least ninety (90) days prior to your annual renewal date. At least forty-five (45) days prior to the date that you must submit your certification of continued eligibility, we will send you a notice of your obligation to re-certify.

2. **Health Care through an HMO.** This contract provides coverage through an HMO. In an HMO, all care must be Medically Necessary and provided, arranged or authorized in advance by your PCP.

   Except for emergency care and for certain obstetric and gynecological services, there is no coverage for care you receive without the approval of your PCP. In addition, coverage is only provided for care rendered by a Participating Provider, except in an emergency or when your PCP refers you to a Non-Participating Provider. A Participating Provider is a professional provider or facility that has an agreement with us to provide health services to members.

   It is your responsibility to select a PCP from the list of PCPs when you enroll for this coverage. You may change your PCP by calling Member Services. We ask that you notify us 30 days before seeing your new PCP. However, we may waive this time frame due to extenuating circumstances. The PCP you have chosen is referred to as "your PCP" throughout this Contract.

   In addition, each female member should select a Participating Provider of obstetric and gynecological services. You may access primary and preventive gynecological services, care related to a pregnancy or care for an acute gynecological condition directly from this selected Participating Provider.

3. **Words We Use.** Throughout this Contract, (Preferred Care) will be referred to as "we," "us" or "our." The words "you," "your" or "yours" refer to you, the person to whom this Contract is issued and who is named on the identification card.

4. **Definitions.** The following definitions apply to this Certificate:
   a. **Coinsurance** is a charge, expressed as a percentage of the cost of the service, which you must pay for certain health services provided under this Certificate. You are responsible for the payment of any coinsurance directly to the Participating Provider at the time of service.
   b. **Copayment** is a charge, expressed as a fixed dollar amount, which you must pay for certain health services provided under this Certificate. You are responsible for the payment of any Copayment directly to the Participating Provider when you receive health services.
   c. **Emergency Condition** means a medical or behavioral condition, the onset of which is sudden, 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 attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy or (B) serious impairment of such person's bodily functions or (C) serious dysfunction of any bodily organ or part of such person or (D) serious disfigurement of such person.
   d. **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:

(i) Consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury supported by a thorough examination, history, and tests;

(ii) 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;

(iii) 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

(iv) 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.

e. **Membe**r means the Subscriber and all covered dependents.

f. **Non-Participating Provider** means a professional provider or facility that does not have an agreement with us to provide health services to Members.

g. **Participating Provider** means a professional provider or facility that has an agreement with us to provide health services to Members.

h. **Primary Care Physician** ("PCP") means a Participating Provider who has an agreement with us to provide primary health care services to Members and who is responsible for providing or arranging the Member's care and for maintaining the Member's medical records.

i. **Schedule of Benefits** means the schedule attached to this Certificate that sets forth the amount of any copayments, coinsurance, and/or deductible applicable to covered services.

j. **Subscriber** means the individual to whom this Certificate is issued.

SECTION TWO - WHO IS COVERED

1. **Who is Covered Under this Contract.** You, the Subscriber to whom this Contract is issued, are covered under this Contract. If you selected other than individual coverage, the following members of your family may also be covered:
   a. Your spouse, if they live or reside in our service area or with you, unless you are divorced or the marriage has been annulled.
   b. Your unmarried children who are under nineteen [19] years of age.
   c. Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness or developmental disability, as defined in the New York Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age at which coverage under the Contract would otherwise have terminated. A physician (who must be a Participating Provider if the child is already a member of Preferred Care) must certify to the child's disability in a form we determine. Such certification must be approved by our Medical Director or designee. You must file a "Handicapped Dependent Application" (available from Member Services) upon enrollment or within sixty (60) days after the date the dependent coverage would otherwise terminate.
   d. Your unmarried children who are nineteen [19] years of age or older, but under twenty-three [23] years of age and who are enrolled as full-time students (at least 12 credit hours per semester) at an accredited institution of learning, and who are not eligible for health insurance through their employer.
   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.

2. **Other Children Covered Under this Contract.** In addition to your natural children, the following other children may also be covered under this Contract:
   a. A legally adopted child;
   b. A stepchild who is dependent upon you for support;
   c. A child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption becoming final;
   d. Children for whom you are the legal guardian and who are chiefly dependent upon you for support and maintenance.

3. **Newborn Child.** If you have a type of coverage that would cover a newborn, your newborn child will be covered at birth, provided that you notify us within thirty (30) days of the birth by completing an enrollment form to add your child to your coverage. When an Enrollment Form is received more than thirty (30) days after the birth date, coverage will begin on the first of the month following the receipt of the completed Enrollment Form. If you are changing the type of coverage in order to cover a newborn child, then you must complete an enrollment form within thirty [30] days of the birth to include your child and pay any additional premium that might be required. If your child gives birth, your newborn grandchild will not be covered.

4. **Adopted Newborns.** If you have a type of coverage that would cover a newborn, or switch to a type of coverage that will cover a newborn, we will cover a proposed adoptive newborn from the moment of birth if you, the adoptive parent, take physical custody of the infant as soon as the infant is released from the hospital after birth and you file a petition pursuant to Section 115-C of the New York State Domestic Relations Law within thirty [30] days of the infant's birth. However, we will not provide coverage for the initial hospital stay of the adopted newborn if one of the child's natural parents has coverage available to cover the newborn's initial hospital stay. We will also not provide coverage for the newborn if a notice of revocation of the adoption has been filed or one of the natural parents revokes consent to the adoption.

SECTION THREE – HOSPITAL BENEFITS

The following benefits are subject to copayments, coinsurance, and/or deductibles, as indicated in the attached Schedule of Benefits.

1. **Hospital Defined.** A Hospital means a facility which is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons; has organized departments of medicine and major surgery; has a requirement that every patient must be under the care of a physician or dentist; provides 24-hour nursing service by or under the supervision of a registered professional nurse; if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861(k) of the United States Public Law 89-97 (42 USC 1395x[k]); is duly licensed by the agency responsible for licensing such hospitals; and is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, education or rehabilitory care.
2. **Care In a Hospital.** You are covered for Medically Necessary care as an inpatient in a Hospital if all the following conditions are met:
   a. Except if you are admitted to the Hospital in an Emergency or your PCP has arranged for your admission to a Non-Participating Hospital, the Hospital must be a Participating Provider.
   b. Except in an emergency, your admission is authorized in advance by your PCP [where you are admitted as an inpatient through the emergency room of a hospital, you should call your PCP within 24 hours of admission, or as soon as is reasonably possible so that we can coordinate your care.
3. **Covered Inpatient Services.** Covered inpatient services include the following:
   a. Daily room and board, including special diets;
   b. General nursing care;
   c. Services, supplies, and equipment related to surgical operations, cystoscopy, recovery facilities, anesthesia, and facilities for intensive or special care;
   d. Diagnostic and therapeutic items, such as drugs and medication, sera, biologicals, vaccines, intravenous preparations;
   e. Dressings and casts;
   f. Blood and blood products furnished in connection with surgery or inpatient hospital services;
   g. Services, supplies and equipment in connection with oxygen, anesthesia, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;
   h. Any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital, except to the extent that they are excluded by this Contract.
4. **Maternity Care.** Other than for perinatal complications, we will provide coverage for inpatient maternity care in a hospital for the mother and inpatient newborn care in a hospital for the infant, if covered under this contract, for at least forty-eight [48] hours following a delivery and at least ninety-six [96] hours following a Caesarean Section. If the mother chooses to be discharged earlier than forty-eight [48] hours after delivery [ninety-six (96) hours in the case of Caesarean Section] and requests a home care visit before the end of those time frames, then coverage will include a home care visit. The home care visit shall not be subject to deductibles, coinsurance, or copayments.
   Maternity care shall include the services of a midwife licensed pursuant to and practicing consistent with New York Education Law and affiliated or practicing in conjunction with a facility licensed pursuant to New York Public Health Law. However, we will not pay for duplicative routine services actually provided by both a licensed midwife and physician. Maternity care shall also include parent

education, assistance and training in breast and bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

5. **Mastectomy Care.** Inpatient hospital care includes coverage of an inpatient hospital stay following a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer. After consulting with you, your attending physician will determine the length of your stay. We also provide coverage for breast prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

6. **Limitations and Exclusions.**
   a. We will not provide any benefits for any day that you are out of the Hospital, even for a portion of the day. We will not provide benefits for any day when inpatient care was not Medically Necessary.
   b. Benefits are paid in full for a semi-private room. If you are in a private room at a Hospital, you must pay the difference between the cost of a private room and a semi-private room unless the private room is Medically Necessary and ordered by your physician.
   c. We will not pay for non-medical items such as television rental or telephone charges.
   d. We will not pay for medications, supplies, and equipment that you take home from the facility.

SECTION FOUR -- MEDICAL BENEFITS

The following benefits are subject to copayment, coinsurance, and/or deductibles, as indicated in the attached Schedule of Benefits.

1. **Your PCP Must Provide, Arrange or Authorize all Medical Services.** Except in an emergency or for certain obstetric and gynecological services, you are covered for the medical services listed below only if your PCP provides, arranges or authorizes the services. You are entitled to medical services provided at one of the following locations:
   a. Your PCP's office.
   b. Another provider's office or a facility if your PCP determines that care from that provider or facility is appropriate for the treatment of your condition.
   c. The outpatient department of a Hospital.
   d. As an inpatient in a Hospital.

2. **Covered Medical Services.** We will pay for the following medical services:
   a. General medical and specialist care, including consultations and referrals.
   b. Preventive health services and physical examinations. We will pay for preventive health services including:
      i. Periodic routine physical examinations for adults aged nineteen (19) and older no more than once every three (3) years.
      ii. Adult immunizations.
      iii. Well child visits for covered children under age nineteen (19) in accordance with the prevailing clinical standards of the Advisory Committee on Immunization Practices (ACIP), including an initial hospital checkup and necessary immunizations as determined by the Superintendent of Insurance in consultation with the Commissioner of Health consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenza type b and hepatitis b and varicella.

We will cover services typically provided in conjunction with a well child visit. Such services include at least: complete medical histories; a complete physical examination; 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; nutrition education and counseling; hearing testing; medical social services; eye screening; tuberculin testing; dental and developmental screening; clinical laboratory and radiological testing; and lead screening.

3. **Diagnosis and treatment of illness or other conditions.** We will pay for the diagnosis and treatment of illness or injury, including:
   a. **Pre-Admission Testing.** We will provide coverage for tests ordered by your physician which are given to you as a preliminary to your admission to the Hospital as a registered bed-patient for surgery if all of the following are met:
      i. The tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;
      ii. You have made a reservation for a Hospital bed and/or the operating room before the tests are given;
      iii. You are physically present at the Hospital where the tests are given;
      iv. Surgery actually takes place within seven (7) days after the tests are given.

   b. **Surgical Services.** We will provide coverage for care in connection with surgery, including any pre- and post-operative care. Surgical care also includes endoscopic procedures and the care of fractures and dislocations of bones.

c. **Anesthesia Services.** This includes the administration of necessary anesthesia and related procedures in connection with a covered surgical service. A Participating Provider other than the Participating Provider performing the surgery or an assistant must provide the services.

d. **Diagnostic X-ray and Laboratory Services.** We will provide coverage for laboratory tests, x-rays and other diagnostic procedures, including ultrasound, CAT scan, and magnetic resonance imaging procedures.

e. **Second Surgical Opinion.** We will provide coverage for a second surgical opinion under the following conditions:
   i. You seek the second surgical opinion after your physician determines your need for surgery;
   ii. The second surgical opinion is rendered by a Participating Provider who is a board certified specialist, and who, by reason of his or her specialty, is an appropriate physician to consider the proposed surgical procedure;
   iii. The second surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under this Contract if such surgery was performed;
   iv. You are examined in person by the Participating Provider rendering the second surgical opinion;
   v. The specialist who renders the second surgical opinion does not perform the surgery.

f. **Second Medical Opinion.** We will cover a second medical opinion provided by an appropriate specialist, including one affiliated with a specialty care center, where there has been a positive or negative diagnosis of cancer, or a recommendation of a course of treatment of cancer. The specialist rendering the second medical opinion must be a Participating Provider to whom you have received a referral by your attending physician, unless you have received a referral from your attending physician to a Non-Participating Provider.

4. **Radiological Services, Chemotherapy and Hemodialysis.** We will pay for radiologic services and chemotherapy, including injections and medications provided at the time of therapy. We will pay for hemodialysis services in your home or at a facility, whichever we deem appropriate.

5. **Obstetrical and Gynecological Services.** You may receive the following services from a qualified Participating Provider of obstetric and gynecologic services without your PCP's authorization:
   a. Up to two (2) annual examinations for primary and preventive obstetric and gynecologic care; and
   b. Care required as a result of the annual examinations or as a result of an acute gynecological condition.

6. **Maternity Care.** Maternity care includes the first visit upon which a positive pregnancy test is determined. It also includes subsequent prenatal and postpartum care. You do not need an approved referral from your PCP for maternity care; however, the care received must be received from a Participating Provider.

7. **Cervical Cancer Screening.** If you are a female who is aged eighteen (18) or older, we will provide coverage for an annual cervical cytology screening for cervical cancer and its precursor states. Cervical cytology screening shall include an annual pelvic examination, collection, and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

8. **Mammography Screening.** We will provide coverage for mammography screening for occult breast cancer, subject to the following schedule:
   a. Upon the recommendation of a physician, a mammogram at any age if you have a prior history of breast cancer or if your mother or sister has a prior history of breast cancer;
   b. A single baseline mammogram for women aged thirty-five (35) through thirty-nine (39), inclusive;
   c. An annual mammogram for women aged forty (40) and older.
   d. In no event shall coverage pursuant to this section include more than one annual screening.

9. **Post-Mastectomy Breast Reconstruction Surgery.** We will provide coverage for all stages of reconstruction of the breast on which the mastectomy has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined by the attending physician and the patient to be appropriate.

10. **Home Health Care**. Coverage for home health care will be provided for up to 40 post-hospital or post-surgical visits in a calendar year given by a certified home health agency or licensed home care services agency. Post-surgical includes surgery performed in an inpatient or outpatient setting, including a physician's office or an ambulatory surgery center. Post-hospital includes inpatient hospital admissions and visits to the emergency room. Home care visits must be related to an illness or injury for which you were hospitalized or for which you received surgery. A treatment plan must be established and approved in writing by your physician.

    Home care consists of one or more of the following:

    a. Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse;
    b. Part-time or intermittent home health aide services that consist primarily of direct care rendered to you;
    c. Physical, occupational or speech therapy provided by the home health agency;
    d. Medical supplies, drugs and medications prescribed by your physician, laboratory services by or on behalf of a certified home health agency or licensed home care services agency.

    For the purpose of determining the benefits for home care are available to a covered person, each visit by a member of a home care team shall be considered as one home care visit. Four hours of home health aide service shall be considered as one home care visit.

11. **Physical Therapy.** Coverage will be provided for up to 30 post-hospital or post-surgical visits per calendar year for physical therapy following surgery or a hospital stay when services are rendered by a licensed physical therapist. Post-surgical includes surgery performed in an inpatient or outpatient setting, including a physician's office or an ambulatory surgery center Post-hospital includes inpatient hospital admissions and visits to the emergency room. Physical therapy visits must be related to an illness or injury for which you were hospitalized or for which you received surgery.

12. **Prostate Cancer Screening.** Coverage for diagnostic screenings for prostate cancer when prescribed by a health care practitioner legally authorized to prescribe under Title 8 of the New York Education Law. Coverage for prostate screenings shall be subject to the following limitations:

    a. Men with a prior history of prostate cancer. Coverage will be provided for standard diagnostic testing for men of any age who have had a prior history of prostate cancer.
    b. Men at risk. Coverage will be provided for one standard diagnostic exam in each year for men age 40 and over who have a family history of prostate cancer or who have other risk factors for prostate cancer.
    c. Coverage will be provided for one standard diagnostic exam in each year for men 50 years of age and older.

    A standard diagnostic exam includes, but is not limited to, a digital rectal exam and a prostate specific antigen (PSA) test.

SECTION FIVE -- EMERGENCY CARE

The emergency care benefits described apply both when you are within or out of the Service Area.

1. **Emergency Condition.** We will provide coverage for care at an emergency room of a Participating Provider or Non-Participating Provider if your illness or condition is considered an Emergency Condition.

   An Emergency Condition is a medical or behavioral condition, the onset of which is sudden, 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 attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or, in the case of a behavioral condition placing the health of such person or others in serious jeopardy; or (B) serious impairment to such person's bodily functions; or (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.

2. **Authorization.** If your condition is an Emergency Condition as set forth above, you do not need to obtain authorization from your PCP prior to receiving care at an emergency room. When you have received emergency room care for an emergency condition, you or a member of your family should notify your PCP within 48 hours so that your follow-up care can be coordinated by a Participating Provider. If it was not reasonably possible to give notice within that time, notice should be given as soon thereafter as it is reasonably possible.

3. **Non-Participating Providers.** We will provide coverage in a Non-Participating Provider only for as long as your PCP and we determine that the emergency room care was Medically Necessary and that your medical condition prevented your transfer to a Participating Provider.

SECTION SIX -- OTHER COVERED SERVICES

1. Diabetic Equipment and Supplies.

We will pay for the following equipment and supplies for the treatment of diabetes which are Medically Necessary and prescribed or recommended by your PCP or other Participating Provider legally authorized to prescribe under Title VIII of the New York State Education Law:

a. Blood glucose monitors;
b. Blood glucose monitors for legally blind;
c. Data management systems;
d. Test strips for monitors and visual reading;
e. Urine test strips;
f. Injection aids;
g. Cartridges for visually impaired;
h. Insulin;
i. Syringes;
j. Insulin pumps and appurtenances thereto;
k. Insulin infusion devices;
l. Oral agents; and
m. Additional equipment and supplies designated by the Commissioner of Health as appropriate for the treatment of diabetes.

Repair, replacement and adjustment of the above diabetic equipment and supplies are covered when made necessary by normal wear and tear. Repair and replacement of diabetic equipment and supplies made necessary because of loss or damage caused by misuse or mistreatment are not covered.

2. Diabetes Self-Management Education.

We will pay for diabetes self management education provided by your PCP or another Participating Provider. Education will be provided upon the diagnosis of diabetes, a significant change in your condition, the onset of a condition that makes changes in self-management necessary or where re-education is Medically Necessary as determined by us. We will also pay for home visits if Medically Necessary.

3. Prescription Drugs.

a. **Scope of Coverage.** We will pay for those FDA approved drugs that require a prescription, including contraceptive drugs. We will also pay for Medically Necessary enteral formulas prescribed by your PCP or other Participating Provider legally authorized to prescribe under Title VIII of the Education Law. Such written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic disability, mental retardation or death. We will also provide coverage for modified solid food products that are low protein, or which contain modified protein which are Medically Necessary for the treatment of certain inherited diseases of amino acid and organic acid metabolism.

b. **Participating Pharmacy.** We will only pay for prescription drugs for use outside of a Hospital. The prescription must be issued by a Participating Provider and filled at a Participating Pharmacy, except in an emergency or where otherwise authorized by Us.

c. **Exclusions and Limitations.** Under this Section we will not pay for the following:

- i. Any prescription drug that we determine is not Medically Necessary, unless coverage is recommended by an External Appeal Agent.
- ii. Experimental or investigational drugs, unless recommended by an External Appeal Agent.
- iii. Nutritional supplements taken electively.
- iv. Non-FDA approved drugs except that we will pay for a prescription drug that is approved by the FDA for treatment of cancer when the drug is prescribed for a different type of cancer than the type for which FDA approval was obtained. However the drug must be recognized for treatment of the type of cancer for which it has been prescribed by one of these publications: AMA Drug Evaluations; American Hospital Formulary Service; U.S. Pharmacopoeia Drug Information; or a review article or editorial comment in a major peer-reviewed professional journal.
- vi. Devices and supplies of any kind, except those related to the care of diabetes and home health care.
- vii. Drugs that require a prescription but an exact equivalent is available over the counter (OTC), unless the prescription drug is Medically Necessary,
- viii. Drugs prescribed for cosmetic use, unless Medically Necessary.
- ix. Prescription drugs used in the treatment of erectile dysfunction when prescribed for use by a person who is required to register as a sex offender pursuant to Article six-C of the Correction Law.

SECTION SEVEN - ADDITIONAL INFORMATION ON HOW THIS PLAN WORKS

1. **When a Specialist Can Be Your PCP.** If you have a life threatening or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may receive a referral to a network specialist with expertise in treating such disease or condition who shall be responsible for and capable of providing and coordinating your primary and specialty care. In such case, the designated specialist is permitted to treat you without a referral from your PCP and may authorize such referrals, procedures, tests and other medical services as your PCP would otherwise be permitted to provide or authorize, subject to the terms of a treatment plan approved by us, in consultation with your PCP, the specialist and you or your designee.
2. **Standing Referral to a Network Specialist.** If we, or your PCP in consultation with us and a participating specialist, if any, determine that you need ongoing specialty care, you may receive a "standing referral" to a specialist who is a Participating Provider. This means that you will not need to obtain a new referral from your PCP every time you need to see that specialist. Such a referral shall be pursuant to a treatment plan approved by us in consultation with your PCP, the specialist and you or your designee, and may limit the number of visits or the period during which such visits are authorized.
3. **Standing Referral to a Specialty Care Center.** If you have a life-threatening or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may receive a standing referral to a network specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. If we, or your PCP or specialist in consultation with our Medical Director, determine that your care would most appropriately be provided by a specialty care center, we will refer you to such center. Any such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by us, in consultation with your PCP and specialist, when applicable.

   For purposes of this provision, a specialty care center is one that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating your life-threatening or disabling condition or disease.
4. **When Your Provider Leaves the Network.** If you are undergoing a course of treatment when your provider leaves our network, then you may be able to continue to receive care from the former Participating Provider, in certain instances, for up to ninety (90) days after you are notified by us of the provider's leaving. If you are pregnant and in your second trimester, you may be able to continue care with the former provider through delivery and postpartum care directly related to the delivery.

   However, in order for you to continue care with a former Participating Provider, the provider must agree to accept our payment and to adhere to our procedures and policies, including those for assuring quality of care.
5. **When New Members are in a Course of Treatment.** If you are in a course of treatment with a Non-Participating Provider when you enroll with us, you may be able to receive care from the Non-Participating Provider for up to sixty (60) days from the effective date of enrollment under this Contract. The course of treatment must be for a life threatening or degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if you are in the second trimester of a pregnancy when you become covered under this Contract. You may continue care through delivery and any post-partum services directly related to the delivery.

   However, in order for you to continue care, the Non-Participating Provider must agree to accept our payment and to adhere to our policies and procedures including those for assuring quality of care.

SECTION EIGHT -- PRE-EXISTING CONDITIONS

In addition to the exclusions and limitations described in other sections of this Contract, we will not provide coverage for Pre-Existing Conditions.

Pre-Existing Conditions. We will not provide coverage for any services related to a Pre-Existing Condition until you have been continuously covered under this Contract or by other Creditable Coverage for at least twelve (12) consecutive months. A Pre-Existing Condition is any physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received by a licensed health care provider within the six (6) month period preceding the Enrollment Date. The Enrollment Date is the earlier of your effective date under this Contract or the date that you file a substantially complete application for coverage with us.

You may receive credit toward the waiting period for any time that you were covered under Creditable Coverage if there was no break in coverage greater than sixty- three (63) days between the termination of the previous coverage and your Enrollment Date under this Contract. In the case of previous HMO coverage, any affiliation period before coverage became effective shall be considered as time covered for purposes of providing credit for previous coverage. Creditable Coverage includes a group health plan, health insurance coverage, Medicaid, Medicare, government-sponsored health benefit programs such as CHAMPUS, Peace Corps or Indian Health Service; Federal Employees Health Benefits Program, state health benefits risk pool or coverage under any health insurance plan sponsored by a state, county or other political subdivision, State Children's Health Insurance Program as well as public health plans of the federal government or of foreign governments.

Notwithstanding the pre-existing condition waiting period provision set forth in paragraph 1., of your Certificate, individuals eligible for a federal tax credit for payment of health insurance premiums, pursuant to the federal Trade Adjustment Act of 2002, who have 3 months of creditable coverage prior to the enrollment date with no break in coverage greater than 63 days, shall not be subject to a pre-existing condition waiting period.

Genetic information in the absence of a diagnosis of the condition related to such genetic information is not a Pre-Existing Condition under this Contract. In addition, no Pre-Existing Condition waiting period shall apply to an individual who is covered under Creditable Coverage on the thirtieth (30th) day after birth, and no Pre-Existing Condition waiting period shall apply to a child under age eighteen (18) who is adopted or placed for adoption and who is covered under Creditable Coverage on the thirtieth (30th) day after adoption or placement, so long as there is no break in coverage of more than sixty-three (63) days between the end of such Creditable Coverage and the Enrollment Date under this Contract. Pregnancy, existing at the time of enrollment, is subject to a credit for previous creditable coverage for a period not to exceed ten (10) months.

Additionally, a Pre-Existing Condition exclusion shall not apply to an Eligible Person. An Eligible Person is a person who had at least eighteen (18) months of Creditable Coverage, who has taken and exhausted his/her COBRA or other continuation coverage not more than sixty-three (63) days prior to his/her enrollment date. An Eligible Person's most recent prior Creditable Coverage must have been under a group health plan, governmental plan, or church plan and must not have been terminated for fraud, intentional misrepresentation, or nonpayment of premiums. In addition, an Eligible Person must not have any other health insurance coverage and must not be eligible for coverage under a group health plan, Medicare, or Medicaid.

SECTION NINE -- LIMITATIONS AND EXCLUSIONS

1. **Experimental and Investigational Procedures and Items.** We will not pay for Experimental and Investigational Procedures and Items not recognized to be therapeutically effective. An Experimental and Investigational Procedure 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 procedures not recognized as therapeutically effective are procedures which require the use of technology that requires federal or government agency approval, which approval may have been granted but the procedure has been determined by the medical community in which the procedure was performed to be outdated; outmoded; or otherwise no longer considered to be a reasonably effective procedure to treat the specific condition. The term "technology" refers to any medical or surgical treatment; medical or surgical device; therapeutic or diagnostic procedure; drug; biological or therapeutic or diagnostic agent. The final determination of whether a procedure is considered nonstandard or unevaluated or not recognized as therapeutically effective is ours alone based upon a review of the appropriate medical authority.
    a. In making this determination, our medical professionals, chosen solely by us, will evaluate each procedure considering criteria such as, but not limited to how Medicare would treat the procedure for coverage:
        (i) That the technology has final approval from the appropriate government regulatory bodies;
        (ii) That the scientific evidence permits conclusions concerning the effect of the technology on health outcome;
        (iii) That the technology improves the net health outcome;
        (iv) That the technology is as beneficial as any established alternatives; and
        (v) That improvement must be attainable outside the experimental or investigational setting.

       The same criteria will be used to evaluate each procedure. No benefits will be provided for a procedure if, the technology does not meet this and other appropriate criteria and is determined by us to be experimental or investigational or not recognized as therapeutically effective.
    b. In addition to the above criteria considered by us and any other criteria, the procedure to be performed must meet all of the following criteria:
        (vi) It must be required and appropriate for the care of the sickness or injury requiring treatment;
        (vii) It must be given in accordance with generally accepted principles of medical practice in the United States at the time the services are furnished;
        (viii) It must be approved for reimbursement by CMS (Medicare); and
        (ix) It must not be furnished in connection with medical or other research.

    In general, the Preferred Care does not cover experimental or investigational treatments (nonstandard/unevaluated treatments or items). However, Preferred Care shall cover an experimental or investigational treatment approved by an External Appeal Agent certified by the State. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Preferred Care will only cover the costs of services required to provide treatment to you according to the design of the trial. Preferred Care shall not be responsible for the costs of investigational drugs or devices, the costs of non-heath care services, the costs of managing research, or costs which would not be covered under the Subscriber Contract for non-experimental or non-investigational treatments which are provided in such clinical trials. (For further information on external appeals, consult your Member Handbook).
2. **Non- Medically Necessary Care.** In general, we will not cover any health care service that is determined not to be Medically Necessary. Medically Necessary means the use of services or items, as described in this Contract, 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:

a. Consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury supported by a thorough examination, history, and tests;
b. 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;
c. 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
d. 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.

If an External Appeal Agent certified by the State overturns our denial, however, we shall cover the procedure, treatment, service or pharmaceutical product, for which coverage has been denied, to the extent that such procedure, treatment, service or pharmaceutical product is otherwise covered under the terms of this Contract. See Section Fourteen of this Contract for further information on External Appeal.

3. **Cosmetic Surgery.** We will not provide coverage for cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

4. **Routine Foot Care.** We will not provide coverage for foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.

5. **Subluxation.** We will not provide coverage for care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for 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.

6. **Government Programs.** We will not provide coverage for treatment provided in a government hospital; benefits provided under a governmental program, any state or federal workers' compensation to the extent that services were provided, employer's liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made.

7. **Dental Care.** 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, dental appliances, dental devices, and dental examinations), except for dental care or treatment due to accidental injury to sound natural teeth within twelve (12) months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.

8. **Vision and Hearing Care.** We will not provide coverage for eyeglass, contact lenses, hearing aids, and examination for the prescription and fitting thereof.

9. **Medicare.** We will not provide coverage for any service or care for which benefits are payable 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 that

Medicare will cover if you have elected Part B or Medicare would have covered if you had elected Part B.

10. **Non-Covered Services.** Covered Services for the Healthy New York Program are set by law. We will not provide coverage for any service or care that is not specifically described as a covered service herein even when a Participating Provider considers the service or care to be Medically Necessary and appropriate. Examples of services not covered include mental health care, chemical abuse/ chemical dependency treatment services.
11. **Unauthorized Services.** Except for emergency care and certain obstetric and gynecological care, we will not provide coverage for any service or care unless the treatment is performed, authorized, or arranged in advance by your PCP.
12. **Custodial care.**
13. **Rest cures.**
14. **Ambulance and transportation services.**
15. **Mental health and psychiatric treatment**, services or treatment for mental retardation or chronic mental illness or enrollment in special schools.
16. **Chemical abuse/chemical dependency services.**
17. **Outpatient speech, occupational, or respiratory therapy,** except as covered in the home health benefit.
18. **Hospice care.**
19. **Prosthetics and orthotics.**
20. **Durable medical equipment.**
21. **Skilled nursing facilities.**
22. **Services intended solely to induce pregnancy**. Coverage of services related to infertility is limited only to services for the diagnosis and treatment of correctable medical conditions
23. **Payment for services that would normally be provided without charge**.
24. **Pretrial or court testimony**, court-ordered treatment, and the preparation of court related reports are not a benefit unless the Medically Necessary treatment would be otherwise covered under the Contract.
25. **Treatment of an illness, accident or medical condition arising out of:a rio**t, or insurrection, war or act of war (whether declared or undeclared), and service in the Armed Forces or auxiliary thereto.
26. **Any service, care, supply or equipment which is not specifically covered under this Certificate**.
27. **Drugs, procedures and supplies for the treatment of erectile dysfunction** when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to Article six-C of the Correction Law..

28. **Felony**. 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.

SECTION TEN - PREMIUMS FOR THIS CONTRACT

1. **Amount of Premiums.** The amount of premium for this Contract is determined by us and approved by the Superintendent of Insurance of the State of New York.

2. **Grace Period.** All premiums for this Contract are due on the first of the month. However, we will allow a thirty (30) day grace period for the payment of all premiums, except the first month's premium. This means that, except for the first month's premium, if we receive payment within thirty (30) days of the date the payment was due, we will continue coverage under this Contract for the entire period covered by the payment. If we do not receive payment within the thirty (30) day grace period, the coverage under this Contract will terminate as of the last day of the month when payment is due.

3. **Agreement to Pay For Services if Premium is Not Paid.** You are not entitled to any services for periods for which the premium has not been paid. If services are received during such period, you agree to pay for the services received.

4. **Change in Premiums.** If there is to be an increase or decrease in the premium for this Contract, we will give you at least thirty (30) days written notice of the change.

SECTION ELEVEN - TERMINATION OF COVERAGE

Described below are the reasons why your coverage under this Contract may terminate. Unless otherwise set forth below, we will give you at least thirty (30) days prior notice of termination of your coverage. All terminations are effective on the date specified. Coverage under this plan is not vested. This means that you do not have any rights to continue receiving benefits after coverage terminates, except as described in paragraph 3 below.

1. **For Non-Payment of Premium.** This Contract will terminate at the end of the thirty (30) day grace period if we do not receive your payment. For example, if your premium is due on July 1, and it is not paid by July 31, the end of the thirty (30) day grace period, no payment will be made under this Contract for any service given to your after June 30.
2. **When You Move Outside the Service Area.** This Contract shall terminate when you cease to live or reside permanently in the service area.
3. **When You No Longer Meet Eligibility Requirements.** This Contract shall terminate on its renewal date if you fail to provide us with timely written certification, along with any supporting documentation that we require, demonstrating your continued eligibility and compliance with the applicable terms of the Healthy New York Program.
4. **Change in Family Status.** If you are covered under this Contract as a dependent or spouse of the subscriber, coverage will end when you no longer meet the eligibility requirements of a dependent or spouse.
5. **Termination of the Healthy New York Program.** This Contract shall automatically terminate on the date when the New York State law that establishes the Healthy New York Program is terminated.
6. **Our Option To Terminate This Contract.** We may terminate this Contract at any time for one or more of the following reasons:
   a. Fraud in applying for enrollment under this Contract or in receiving any services.
   b. Such other reasons on file with the Superintendent of Insurance at the time of such termination and approved by him. A copy of such other reasons shall be forwarded to you if we terminate this Contract for such a reason. We will give you no less than thirty (30) days prior written notice of such termination.
   c. Any reason approved by the Superintendent of Insurance and authorized by Health Insurance Portability Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.
   d. Discontinuance of the class of Contracts to which this Contract belongs upon not less than five (5) months prior written notice of such termination.
7. **Your Option to Terminate This Contract.** You may terminate this Contract at any time by giving us at least one (1) month's prior notice. We will refund any full month's portion of the premium for this Contract that has been prepaid by you.
8. **On Your Death.** This Contract will automatically terminate on the date of your death.
9. **Continued Benefits for Total Disability After Termination.** If you are totally disabled on the date this Contract terminates and you have received medical services for the illness, injury or condition which caused the total disability while covered under this Contract, we will continue to pay for the illness, injury or condition related to the total disability during an uninterrupted period of total disability until the first of the following dates:
   a. A date on which you are no longer totally disabled; or
   b. A date twelve (12) months from the date this Contract terminates.

   We will not pay for more care than you would have received if your coverage under this Contract had not terminated.

SECTION TWELVE- RIGHT TO A NEW CONTRACT AFTER TERMINATION

You have a right to convert to a new contract if your coverage under this Contract terminates under the circumstances described below:

1. **Termination on the Death of the Subscriber.** If your coverage under this Contract terminates because of the death of the Subscriber, then you may be entitled to purchase a contract with us as a direct payment subscriber.
2. **Termination of your Marriage.** If your coverage under this Contract terminates because you are divorced or your marriage is annulled, then you may be entitled to purchase a contract with us as a direct payment subscriber.
3. **Termination of Coverage of a Child.** If your coverage under this Contract terminates because you no longer qualify as a dependent, then you may be entitled to purchase a contract with us as a direct payment subscriber.
4. **Termination of the Healthy New York Program.** If the Healthy New York Program is terminated or you no longer meet the eligibility requirements for the Healthy New York Program, then you may be entitled to purchase a contract with us as a direct payment subscriber.
5. **When to Apply for the New Contract.** If you are entitled to purchase a new contract as described above, then you must apply to us for the new contract within thirty-one (31) days after termination of your coverage under this contract. You must also pay the first premium of the new contract within the same thirty-one (31) period.
6. **The New Contract.** If you meet the eligibility requirements, then you may purchase a standard or HDHP Healthy New York individual health insurance contract with us as a Subscriber. Otherwise, the new contract(s) that we will offer on conversion will be our standardized direct payment HMO or HMO Point of Service contracts.

SECTION THIRTEEN - GRIEVANCE PROCEDURE AND UTILIZATION REVIEW APPEALS

1. **Grievance-Procedure.** If the Customer Care Center cannot satisfactorily respond to your concerns and you are in any way dissatisfied with our response to your issues or problems, you have a right to file a complaint. If you wish to appeal a previous decision associated with a denial of services or benefits, you have the right to access our dispute process. Details of the complete complaint and dispute process can be found in your Member Handbook and are also available by request from Member Services.]
2. **Utilization Review Appeals.** Details on how to appeal a determination that a service is not medically necessary can be found in your Member Handbook and are also available by request from Member Services.

SECTION FOURTEEN – EXTERNAL APPEAL

1. **Non-Medically Necessary Care.**
   In general, we will not cover any health care service that is not Medically Necessary. If an External Appeal Agent certified by the State overturns our denial, however, we shall cover the procedure, treatment, service, or pharmaceutical product for which coverage had been denied, to the extent that such procedure, treatment, service, or pharmaceutical product is otherwise covered under the terms of this Contract. For further information on external appeals, consult your Member Handbook.

2. **Experimental/Investigational Treatments.**
   In general, we do not cover experimental or investigational treatments. However, we shall cover an experimental or investigational treatment approved by an External Appeal Agent certified by the State. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Contract for non-experimental or non-investigational treatments provided in such clinical trial. For further information on external appeals, consult your Member Handbook.

SECTION FIFTEEN - GENERAL PROVISIONS

1. **No Assignment.** You cannot assign the benefits of this Contract. Any assignment or attempt to do so is void. Assignment means the transfer to another person or organization of your right to the benefits provided by this Contract.
2. **Legal Action.** You must bring any legal action against us under this Contract within twelve (12) months from the date we refused to pay for a service under this Contract.
3. **Amendment of Contract.** We may change this Contract if the change is approved by the Superintendent of Insurance of the State of New York. We will give you at least thirty (30) days written notice of any change.
4. **Medical Records.** In order to administer this Contract, it may be necessary for us to obtain your medical records from hospitals, physicians, or other providers who have treated you, or other plans or insurers. When you become covered under this Contract, you give us permission to obtain and use such records.
5. **Confidentiality of Health Care Records**. By being a Member, you and your covered 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 Member Services.
6. **Who Receives Payment Under This Contract.** We will pay Participating Providers directly to provide services to you. If you receive covered services from any other provider, we reserve the right to pay either you or the provider.
7. **Notice.** Any notice under this Contract may be given by United States mail, postage prepaid, addressed as follows:

If to us: **Preferred Care**
259 Monroe Avenue
Rochester, NY 14607

If to you: To the latest address provided by you on enrollment or official change-of-address form.

SCHEDULE OF BENEFITS

Covered Service	*Member Pays*
Inpatient Hospital Services (including inpatient maternity care) Daily room & board General nursing care Special Diets Miscellaneous hospital services & supplies	 $ 500 copayment per continuous confinement.
Outpatient Hospital Services Diagnostic and treatment services Outpatient surgery	 $ 20 copayment per visit $ 75 facility copayment
Physicians Services Diagnostic & treatment services Consultant & referral services Anesthesia services Second surgical opinion Second opinion for cancer Surgical services (including breast reconstruction following a mastectomy)	 $20 copayment per visit 20% or $ 200, whichever is less
Pre-admission Testing	$ 20 copayment
Maternity Care Prenatal care Postnatal care Delivery Home Visit	 $ 10 copayment per visit (prenatal) $ 10 copayment per visit (postnatal) 20% or $200, whichever is less No copayment
Adult Preventive Health Care	

Covered Service	*Member Pays*
Mammography screening Cervical cytology screening Periodic physical examinations Prostate Cancer screening Adult immunizations	$ 20 copayment per visit
Child Primary & Preventive Health Services Preventive & primary care Immunizations Scheduled Well-Child Visits	No copayment
Diabetic Equipment & Supplies and Self-Management Education	$ 20 copayment per visit for self-management education $ 20 copayment per each item of equipment $ 20 copayment per 34-day supply of insulin, hypoglycemics and supplies
Diagnostic X-Ray & Lab Services	$20 copayment per visit

Covered Service	*Member Pays*
Emergency Services	$ 50 copayment per visit (waived if hospital admission results from visit)
Home Health Care	$20 copayment per visit
Physical Therapy	$20 copayment per visit
Therapeutic Services Radiological services Chemotherapy Hemodialysis	 $ 20 copayment per visit
Blood and Blood Products	$ 20 copayment per visit
Prescription Drugs	<u>Deductible</u>: $ 100 per person per calendar year <u>Copayment</u>: $ 10 per generic drug per 34-day supply $ 20 per brand name drug plus difference in cost between the brand name drug and its generic equivalent per 34 day supply Mail order program $ 20 per generic drug per 90-day supply $ 40 per brand name drug per 90-day supply plus difference in cost between brand name and its generic equivalent <u>Benefit Maximum</u> $ 3000 per person per calendar year