



## PREFERRED PROVIDER ORGANIZATION CONTRACT OF COVERAGE PPO Conversion Plan

We are pleased to provide you this Health Care Contract with Preferred Assurance Company, Inc., commonly known as Preferred Care (called Preferred Care in this Contract), 259 Monroe Avenue, Rochester, New York 14607. We can be reached by phone at (585) 258-8049 or (800) 950-3224. TTY users may call (585) 325-2629 or (800) 252-2452.

This Contract is provided to each Subscriber who has enrolled in Preferred Care through the PPO Conversion Plan. This Contract, along with along "Explanation of Benefits, Copayments & Coinsurance", the "Prior Justification List", your Enrollment Form, identification card, and any amendments added now or in the future comprise the Contract between you and Preferred Care. This Contract explains the Covered Benefits and other terms of your Preferred Care coverage. 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 Contract, the Member agrees to abide by the rules as described in this Contract. Members are eligible to receive Medically Necessary services and benefits described in this Contract in exchange for the Premium paid to Preferred Care.

This Contract offers each Member the option to receive covered services on two benefit levels:

**In-Network Benefits.** In-Network Benefits are the highest level of coverage available. In-Network Benefits apply when your care is provided by In-Network Providers. You should always consider receiving health care services first through the In-Network Benefits portion of this Contract.

**Out-of-Network Benefits.** The Out-of-Network Benefits portion of this Contract covers health care services described in this Contract when you choose to receive the covered services from Out-of-Network Providers. When you receive Out-of-Network Benefits, you will incur higher out-of-pocket expenses. You will be responsible for meeting an annual Deductible and paying a Coinsurance amount, as well as paying any difference between the Covered Expenses and the provider's charge.

**Read This Entire Contract Carefully. It describes the benefits available under the Contract. It is your responsibility to understand the terms and conditions in this Contract.** 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.

You may cancel this Contract within ten (10) days after it has been delivered to you and any Premiums paid will be refunded.

Preferred Care

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

---

President and Chief Executive Officer

## Table of Content

PREFERRED PROVIDER ORGANIZATION CONTRACT OF COVERAGE .....	1
Table of Content .....	2
Section A: Definitions .....	3
1. Definitions .....	3
Section B: Eligibility , Enrollment and Effective Date of Coverage .....	8
1. Medicare Eligibility .....	8
2. Financial Eligibility.....	8
3. Subscriber. ....	8
4. Enrollment. ....	10
5. Effective Date of Coverage.....	11
6. Renewal Date. ....	11
Section C: Medically Necessary Services; Cost Sharing Expense.....	12
1. All Care must be Medically Necessary.....	12
2. Prior Justification for Certain Covered Benefits. ....	13
3. Cost Sharing Expense for Covered Benefits.....	14
Section D: Services and Benefits .....	16
1. Health Professional Services .....	16
2. Emergency Care, Urgent Care and Ambulance Services .....	21
3. Maternity and Family Planning Services .....	23
4. Home Health Care, Hospice Care and Home Infusion Services.....	26
5. Inpatient Care .....	29
6. Outpatient and Ambulatory Care.....	33
7. Human Organ and Bone Marrow Transplant .....	37
8. Mental Health Services .....	37
9. Chemical Abuse/ Chemical Dependence Services .....	38
10. Additional Benefits.....	40
Section E: Exclusions and Pre-existing Condition .....	45
Section F: Claims Procedure .....	55
Section G: General Provisions.....	56
Section H: Termination of Coverage.....	67
Section I: Benefits for Total Disability After Termination.....	69
Section J: Right to New Contract After Termination .....	70
Section K: Coordination of Benefits, Third Party Payments and Double Coverage .....	71

## **Section A: Definitions**

### **1. 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. However, if you begin coverage anytime after January 1, the Calendar Year is the period from the date you became covered until December 31.
- C. Coinsurance means a charge, expressed as a percentage of Covered Expenses that you, the Member, must pay for certain services covered under this Contract. You are responsible for the payment of any Coinsurance directly to the Health Professional who has provided services to you. Coinsurance amounts are described on the "Explanation of Benefits, Copayments & Coinsurance" included with and made a part of this Contract. Coinsurance amounts may be changed by us from time to time. (Note: An In-Network Facility or Health Professional may issue billing statements to Members that show amounts that are less than the Covered Expenses for a Covered Service. In certain situations, these amounts do not represent the amount payable under the Plan. The Covered Expense, in these cases, is determined by the agreement between the Facility or Health Professional and Preferred Care.)
- D. Copayment (or Copay) means a charge, expressed as a fixed dollar amount that you, the Member, must pay for certain services and/or items covered under this Contract. You are responsible for the payment of any Copay directly to the Health Professional at the time services or items are received. Copayments are described on the "Explanation of Benefits, Copayments & Coinsurance" included with and made a part of this Contract. Copayments may be changed by us from time to time.
- E. Contract means this document, along with the "Explanation of Benefits, Copayments & Coinsurance," the "Prior Justification List", Covered Benefits and other terms of your Preferred Care coverage.
- F. Contract Year means a period of time commencing at 12:01 A.M. Eastern Time on your effective date and ending December 31<sup>st</sup> 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 1<sup>st</sup> unless otherwise terminated.
- G. Covered Benefits means health care services and items for which coverage is provided under this Contract.
- H. Covered Expense means the maximum amount we will pay to a Facility, Health Professional or Provider of Additional Health Services for the services or supplies covered under this Contract, before any applicable Deductible, Copayment and Coinsurance amounts are subtracted.
- I. Covered Expenses include only those charges for health care services which are less than or equal to the maximum allowable fee schedule of Preferred Care in

effect at the time the service is rendered or the supply is purchased. . Charges that are greater than our maximum allowable fees must be paid by you.

- J. Dependent means anyone who meets all eligibility requirements set forth in Section B: Eligibility , Enrollment and Effective Date of Coverage, who has been enrolled by the Subscriber and for whom the required Premium payment has actually been received by us, and is therefore entitled to Covered Benefits under this Contract.
- K. Deductible means a charge expressed as a fixed dollar amount, which you must pay once each Calendar Year before we will begin to pay anything for Covered Benefits covered under this Contract during the Calendar Year. Deductibles are described on the “Explanation of Benefits, Copayments & Coinsurance” included with and made a part of this Contract.
- L. Effective Date means the date your coverage under this Contract begins. Coverage begins 12:01 a.m. Eastern Standard Time on the Effective Date.
- M. Emergency Condition. An 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:
  - (1) 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
  - (2) Serious impairment to such person’s bodily functions; or
  - (3) Serious dysfunction of any bodily organ or part of such person; or
  - (4) Serious disfigurement of such persons.
- N. Enrollment Form means the document provided by you, 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 Contract.
- O. Facility means: a Hospital; ambulatory surgery Facility; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; an institutional provider of mental health or chemical dependence and abuse treatment operating under Article 31 of the New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or other provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable). If you receive treatment outside of New York State, the Facility must be accredited by the Joint Commission of Accreditation of Health Care Organizations (including accreditation as an alcoholism or chemical dependence and abuse treatment program, if appropriate) and have the appropriate state licensing.
- P. Health Professional means a health care provider who is licensed, certified or otherwise qualified as required by the New York State Insurance Law to provide Covered Benefits as authorized pursuant to such license, certification or other qualification and who charges and bills patients for services. The Health Professional’s services must be rendered within the lawful scope of practice for that type of provider in order to be covered under this Contract.

- Q. Home Health Agency means an agency that provides Skilled Services and other therapeutic services in your home when Medically Necessary. The services provided by the Home Health Agency must be authorized by Health Professional and Preferred Care.
- R. Home Health Care means the care and treatment of a Member who is under the care of a Health Professional but only if:
- (1) You are under the care of a physician who certifies the need for Home Health Care and approves for its provision; and
  - (2) The care is provided by a Home Health Care Agency certified under Article 36 of the New York State Public Health Law or if provided outside the State of New York, under a similar certification process required by the State where such services are provided; and
  - (3) You would otherwise need care in a Hospital or a Skilled Nursing Facility
- S. Hospital means an acute care Hospital licensed by the State and approved by the Joint Commission on Accreditation of Health Care Organizations; certified by Medicare; and, if located in New York State, licensed pursuant to Article 28 of the Public Health Law of New York. A Hospital is a licensed institution primarily engaged in providing:
- (1) Inpatient diagnostic and therapeutic services for surgical and medical diagnosis;
  - (2) Treatment and care of injured and sick persons by or under the supervision of physicians; and
  - (3) Twenty-four (24) hour nursing services by or under the supervision of registered nurses.
- None of the following is considered a Hospital under this Contract:
- (1) Hospitals that are Federal Hospitals;
  - (2) Hospitals that are a place primarily for the treatment of tuberculosis;
  - (3) Hospitals for treatment of mental illness. If you are a patient in a separate division or unit of a Hospital dedicated to the treatment of mental illness where the average length of stay is more than 30 days, that separate division or unit is not considered a Hospital;
  - (4) Places primarily used for nursing care;
  - (5) Places primarily used as a place of rest, custodial care or as domiciles;
  - (6) Skilled Nursing Facilities;
  - (7) Convalescent homes or similar institutions;
  - (8) Infirmaries at schools, colleges, or camps;
  - (9) Places primarily used for the treatment of chemical dependence and abuse;
  - (10) Free standing Ambulatory Surgical Centers.
- T. In-Network Benefits means the highest level of coverage available. In-Network Benefits apply when your care is provided by In-Network Providers.
- U. In-Network Provider means a Facility, Health Provider or Provider of Additional Health Services that has a provider agreement with us to provide health services to Members. We have provider directories that list all of our In-Network Providers.

Provider searches can be done on our web site and copies of the directory are available free of charge upon request.

- V. Medical Director means a physician designated by us to monitor appropriate use of health services and quality of care.
- W. Medically Necessary. See Section C: Medically Necessary Services; Cost Sharing Expense, for complete definition.
- X. Member means any Subscriber or enrolled Dependent who meets all eligibility requirements and for whom the required Premium payment has actually been received by us, and is therefore entitled to Covered Benefits under this Contract.
- Y. Out-of-Network Benefits means when you choose to receive covered services from an Out-of-Network Provider. When you choose to receive Out-of-Network Benefits, you will incur higher out-of-pocket expenses, and if applicable, you may pay any difference between the Covered Expense and the provider's charge.
- Z. Out-of-Network Provider means a Facility, Health Professional or Provider of Additional Health Services that does not have a provider agreement with us to provide health services to Members.
- AA. Out-of-Pocket Maximum means the maximum out-of-pocket amount you will pay for In-Network or Out-of-Network Covered Benefits per Calendar Year, except for those actual charges exceeding the Covered Expense for Out-of-Network services. Out-of-Pocket Maximums are described on the "Explanation of Benefits, Copayments & Coinsurance" included with and made a part of this Contract.
- BB. Preferred Provider Organization (PPO) means a method of health care delivery through which a Member of the PPO selects Health Professionals from among the health care providers participating in the PPO In-Network for the maximum benefit. Members still have access to non-participating providers, but at a lower benefit level.
- CC. Premium means the periodic payment (usually monthly) made to us that entitles you to the benefits in this Contract.
- DD. Prior Justification means that, in order for certain services or items to be a Covered Benefit, those services or items must be clinically reviewed and authorized by us before you receive them. The services or items that require Prior Justification are identified on the "Prior Justification List" included with and made a part of this Contract. Failure to obtain Prior Justification for those services or items may result in reduced coverage for the service or item as noted in Section C: Medically Necessary Services; Cost Sharing Expense, 2.,C of this Contract.
- EE. Provider of Additional Health Services means a provider of services or supplies covered under this Contract (such as diabetic equipment and supplies, prosthetic devices or durable medical equipment) that is not a Facility or Health Professional, and that is licensed or certified according to applicable state law or regulation; approved by the applicable accreditation body, if any; and/or recognized by us for payment under this Contract.
- FF. Skilled Nursing Facility means a Facility that is recognized and certified as such by Medicare, falls within the definition of a Skilled Nursing Facility under Title XVIII of the Social Security Act and is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Health Care Organization. We will provide

coverage for your care in a Skilled Nursing Facility only if we determine that the care you require is a Skilled Service.

- (1) Skilled Services mean a service we determine is a Skilled Nursing or Skilled Rehabilitation Service rendered in a Skilled Nursing Facility, in a Hospital, or in your home at a skilled level of care by or under the direct supervision of licensed medical personnel.
- (2) Skilled Nursing Service means care that can be performed only by, or under the supervision of, licensed nursing personnel on a daily basis to achieve the medically desired results as defined by medical guidelines. (This may be on an intermittent basis for Members receiving home care). A service is not considered a Skilled Nursing Service merely because it is performed or supervised by licensed medical personnel.

GG. Skilled Rehabilitation Service (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).

HH. Subscriber means a person who meets all eligibility requirements, has completed an Enrollment Form and has paid, or has had paid on his or her behalf, all applicable Premiums. The Subscriber is the person to whom this Contract is issued..

II. "We", "Us", "Our" or "The Plan" refers to Preferred Care throughout this Contract.

JJ. "You", "Your", and "Yours" refers to you, the Member, which includes both the Subscriber and, if any, the Subscriber's eligible enrolled Dependents who are covered under this Contract.

## **Section B: Eligibility , Enrollment and Effective Date of Coverage**

### **1. Medicare Eligibility.**

You are not eligible to enroll in this plan if you are entitled to Part A and eligible for Part B of Medicare. If you become eligible for both Medicare Parts A & B subsequent to your enrollment in this plan, you will not be terminated, however, 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.

### **2. Financial Eligibility.**

You are not eligible to enroll in this plan if you have had health insurance coverage terminated within the previous 12 months for failure to pay Premiums.

### **3. Subscriber.**

To be eligible to enroll as a Subscriber you must be converting to this plan from another Preferred Assurance Plan for which you are no longer eligible and you must not be eligible for other comprehensive insurance through your employer. You must enroll within thirty (30) days of the initial loss of eligibility.

A. Dependents. Your Dependents may also be covered under this Contract. We have the right to request and have furnished such proof as we may need to determine the eligibility status of prospective or current Dependents as they pertain to eligibility for coverage under this Contract. To be eligible to enroll as a Dependent the Member must:

B. Be your legal spouse; or

C. Be your Unmarried Dependent Child(ren) who meets the criteria in any of the following categories:

(1) Unmarried Dependent Child(ren) means a child(ren) born to you or your spouse who is:

a. Unmarried; and

b. Under nineteen (19) years of age; and

c. Who is chiefly dependent upon you for support and maintenance; and

d. Who is not eligible for health insurance through his or her employer.

(2) Newborn Child. If your Unmarried Dependent Child is newborn, the following conditions apply:

a. If you have a type of coverage that would cover a newborn, your newborn will be covered from the date of birth provided the notice of birth is given within thirty (30) days of birth by completing the Enrollment Form to add the child to your coverage.

b. If you are changing your type of coverage (for example from individual to family coverage) in order to cover the newborn child, you must complete the Enrollment Form to extend your coverage to include your

child within thirty (30) days of the child's birth. If you do not complete the form within thirty (30) days of the birth, coverage of the child will become effective at time of notice of birth, as long as you have met your premium payment obligations.

- c. Natural children of your Dependent if his/her child meet the criteria in Paragraph 3.A. and C.(1) 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.
- (3) Adopted Child. If you adopt a child while covered under this Contract, the following conditions apply:
- a. Coverage may be provided for a child whom you propose to adopt and who is dependent upon you during the waiting period prior to finalization of the adoption;
  - b. Coverage may be provided for a newly born infant adopted by you if:
    - i. 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
    - ii. No notice of revocation to the adoption has been filed pursuant to New York State Domestic Relations Law, Section 115-b; and
    - iii. Consent to the adoption has not been revoked.
- (4) Legal Guardian. Coverage may be provided for a child for whom you have been appointed the legal guardian by court order and who is chiefly dependent upon you for support and maintenance.
- (5) Stepchild. Coverage may be provided for a stepchild who is:
- a. Unmarried; and
  - b. Under nineteen (19) years of age; and
  - c. Chiefly dependent upon you for support and maintenance; and
  - d. Not eligible for health insurance through his or her employer
- (6) Disabled or Mentally Ill Child. Coverage may be provided for your child regardless of age who is:
- a. Unmarried; and
  - b. Incapable of self-sustaining employment because of one of the following conditions ("Condition"):
    - i. Mental illness as defined in the New York State mental hygiene law; or
    - ii. Developmental disability as defined in the New York State Mental Hygiene Law; or
    - iii. Mental retardation as defined in the New York State Mental Hygiene Law; or:
    - iv. A physical handicap; and
    - v. All of the following criteria are met:

- a.) The Condition must have occurred before the child reached the age at which coverage would otherwise terminate; and
- b.) You have filed a “Handicapped Dependent Application” (available from our Member Services Center) upon enrollment or within sixty (60) days after the date the Dependent coverage would otherwise terminate; and
- c.) The Child must be chiefly dependent upon the Subscriber for support and maintenance; and
- d.) The Condition must be certified by a physician in a form we determine, and the certification approved by our Medical Director or designee.

D. Students. To be eligible to enroll as a Student the person must:

- (1) meet the Dependent eligibility requirements;
- (2) be enrolled as a full time student in a school, college or university accredited by the State of New York or recognized by Preferred Care (even if the child resides at school while it is in session); and
- (3) eligibility of student coverage ends when a student reaches age twenty-three (23).

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, that coverage of a dependent student would end when the student reaches age twenty-three (23). Preferred Care may require that the Medical Necessity of the leave be certified by the student’s attending physician who is licensed to practice in the state of New York.

***Dependent Verification.*** Please note that we have the ongoing right to verify whether a Dependent continues to qualify as a Dependent under this section of the Contract.

#### **4. Enrollment.**

If you enroll for coverage pursuant to this Paragraph, your coverage will begin at 12:01 a.m. Eastern Standard time on the next Premium due date after the loss of prior coverage. 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 Section H: Termination of Coverage, Paragraph, 2.C, of this Contract.

- A. Initial Enrollment. You are entitled to apply for coverage for yourself and your eligible Dependents within thirty (30) days after loss of eligibility from your prior plan. All persons included for coverage must be listed on the Enrollment Form provided.
- B. Newly Eligible Members and Dependents. You may become eligible to enroll at a time that does not fall within the 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 Dependent by completing and submitting to us a signed Enrollment Form within thirty (30) days of that Dependent becoming eligible (e.g. from the date of birth, adoption, marriage, etc.). Proof of eligibility may be required.

- C. 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, Medicare eligibility or age. Failure to notify us of ineligibility may constitute fraud and could result in the termination of your Preferred Care Contract and in civil and/or criminal legal action against you.

If you think there are reasons coverage of the person experiencing the change should continue, you must notify us of the reasons for the continuation of the coverage, on a form provided by us to you for that purpose, together with any requested documentation. No later than sixty (60) days after the date Dependent coverage would usually terminate.

#### **5. Effective Date of Coverage.**

After we receive your completed Enrollment Form, and the appropriate arrangements for payment of Premium are made, your coverage under this Contract will begin on the earliest of the following dates:

- A. Initial Enrollment and Open Enrollment. Coverage shall begin on the first day of the month following your loss of coverage under your prior plan unless a subsequent date is agreed upon by you and Preferred Care.
- B. Newly Eligible Dependents. Coverage will begin as of the date of a qualifying event, such as marriage, birth, adoption, guardianship, but ONLY if the Enrollment Form is received within thirty (30) days of the event. Should the completed enrollment form not be received within thirty (30) days of the birth, coverage of the newborn will become effective at time of notice of birth, provided premium payment obligations are met.
- C. Delivery of Contract. Preferred Care will provide you with a Contract and other Member materials upon enrollment.

#### **6. Renewal Date.**

This Contract will automatically renew each Calendar Year unless terminated as provided for in Section H: Termination of Coverage. Your renewal date will be January 1st of each year.

## **Section C: Medically Necessary Services; Cost Sharing Expense.**

This Section explains when you may be entitled to a Covered Benefit under this Contract. **We strongly recommend that you read through this entire Section so that you may understand when you may be entitled to a Covered Benefit; what steps you must take in order to obtain a Covered Benefit; and what obligations you may have when obtaining a Covered Benefit.** As set out in full detail below, only services that are Medically Necessary, have received the proper Prior Justification (if required), for which you have satisfied all Cost Sharing Expenses, and are described in this Contract will be covered.

### **1. All Care must be Medically Necessary.**

We will provide coverage for the Covered Benefits described in this Contract as long as the care, treatment, hospitalization, service, technology, test, drug or supply (collectively, "Service") that you request or receive is Medically Necessary. The fact that a Health Professional has furnished, prescribed, ordered, recommended, or approved the Service does not make it Medically Necessary or mean that we have to provide coverage for it. We will decide whether care is Medically Necessary. We will base our decision in part on a review of your medical records. We will also evaluate medical opinions we receive. This could include the medical opinion of a professional society, peer review committee or other groups of physicians.

- A. Except as otherwise required by law, no Service rendered to you will be considered Medically Necessary unless we determine that the Service is consistent with the diagnosis and treatment of your medical condition; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative. Please see Section G: General Provisions, for your right to an external appeal of our determination that the Service is not Medically Necessary.
- B. In determining if a Service is Medically Necessary, we will also consider:
  - (1) Reports in peer reviewed medical literature;
  - (2) Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
  - (3) Professional standards of safety and effectiveness, which are generally recognized in the United States of America for diagnosis, care or treatment;
  - (4) The opinion of Health Professionals in the generally recognized health specialty involved;
  - (5) The opinion of the attending Health Professionals, which have credence but do not overrule the contrary opinions; and
  - (6) Any other relevant information brought to our attention.

C. Services will be deemed Medically Necessary only if:

- (1) They are appropriate and consistent with the diagnosis and treatment of your medical condition;
- (2) They are required for the direct care and treatment or management of that condition;
- (3) If not provided, your condition would be adversely affected;
- (4) They are provided in accordance with community standard of good medical practice;
- (5) They are not primarily for the convenience of you, your family, the Health Professional or another provider;
- (6) They are the most appropriate Service and rendered in the most efficient and economical way and at the most economical level of care which can safely be provided to you; and
- (7) When you are an inpatient, your medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided to you in any other setting (e.g., outpatient, physician's office or at home).

**2. Prior Justification for Certain Covered Benefits.**

Our prior approval is required before you receive certain Covered Benefits covered under this Contract. The services subject to prior approval are listed in the "Prior Justification List" attached hereto, and you should review it prior to seeking a Covered Benefit. As set forth below, certain penalties may apply if you fail to obtain Prior Justification for a Covered Benefit that requires it.

- A. **Prior Justification Procedure.** Members who seek coverage for the services listed in the Prior Justification List must call us at the number indicated on their identification card to have the care pre-approved. We request that you call at least seven (7) days prior to a planned inpatient admission.

After receiving a request for approval, we will review the reasons for your planned treatment and determine if benefits are available. We will notify you and your Health Professional of our decision by telephone and in writing within three (3) business days of receipt of your request. If your treatment involves urgent or continued treatment, we will notify you and your Health Professional within one (1) business day of receipt of your request.

If you are hospitalized in cases of an Emergency Condition involving any of these Services, you should call us within 24 hours after your admission or as soon thereafter as reasonably possible in order for any follow-up care to be covered without the reduction described in Subparagraph " 2.C" below. The availability of an organ for transplantation resulting in the necessity for an immediate admission for implantation shall be considered an Emergency Condition for purpose of this paragraph.

- B. **Your Right to Appeal a Prior Justification Determination.** If you or your Health Professional disagrees with our decision, you may appeal our decision using our complaint and dispute process as noted in Section G: General Provisions, of this Contract.

C. **Failure to Seek Prior Justification.** If you fail to seek our prior approval for any of the Covered Benefits that are set out in the “Prior Justification List” attached hereto, we will pay 50% less than we would otherwise have paid for that particular Covered Benefit up to a maximum reduced benefit of \$500, except in the case where hospitalization is required for treatment of an Emergency Condition. This reduced coverage will apply in every instance in which you fail to obtain Prior Justification. You must pay the remaining charges. In every case, however, we will pay for the Covered Benefit only if we determine the Service was Medically Necessary. If we determine that the Service was not Medically Necessary, you will be responsible for paying the entire charge for the Service. No part of any of the above-stated reduced coverage will apply towards your Deductible or Out-of-Pocket Maximum. If you or your Health Professional disagrees with our determination, you may appeal our determination using our complaint and dispute process as noted in Section G: General Provisions, of this Contract.

### **3. Cost Sharing Expense for Covered Benefits.**

When you receive Covered Benefits under this Contract, you may be responsible for payment directly to a Health Professional of any Copayment, Coinsurance and other charges related to the Covered Benefit you receive. Please be sure to check the “Prior Justification List” and the “Explanation of Benefits, Copayments & Coinsurance” attached to this Contract for complete Covered Benefit details, including any requirements for Prior Justification and expenses for which you may be responsible.

- A. **Copayments.** The Copayments you must pay when you are entitled to Covered Benefits are set forth in the “Explanation of Benefits, Copayments & Coinsurance” attached hereto. A Covered Benefit that requires you to pay a Copayment is not subject to a Deductible. Any Copayment you make for an In-Network Covered Benefit will be applied to satisfy your In-Network Out-of-Pocket Maximum; any Copayment you make for an Out-of-Network Covered Benefit will be applied to satisfy your Out-of-Network Out-of-Pocket Maximum, as set forth below.
- B. **Deductible.** Except where stated otherwise, each person covered under this Contract must satisfy the Deductible set forth on the “Explanation of Benefits, Copayments & Coinsurance” attached hereto during the Calendar Year before we will pay Covered Expenses for either In-Network and Out-of-Network Covered Benefits to which a Coinsurance obligation may apply. The In-Network Deductible paid by you will apply to only the In-Network Out-of-Pocket Maximum, and does not carry over to satisfy the Out-of-Network Deductible or the Out-of-Network Out-of-Pocket Maximum. The Out-of-Network Deductible paid by you will apply to both the Out-of-Network Out-of-Pocket Maximum and the In-Network Out-of-Pocket Maximum, and does carry over to satisfy the In-Network Deductible and the In-Network Out-of-Pocket Maximum. If you have other than individual coverage, the Deductible applies to each person covered under this Contract. However, after Deductible payments for any and all persons covered under this Contract reach the total Deductible amount set forth in the “Explanation of Benefits, Copayments & Coinsurance” attached hereto in a Calendar Year, no further Deductible will be required for any person covered under this Contract for that Calendar Year. Covered Benefits requiring a Copayment do not require that you first satisfy the Deductible.

- C. **Coinsurance.** Except where stated otherwise, after you have satisfied the Deductible for the Calendar Year, you will be responsible for a percentage (the “Coinsurance”) of the Covered Expense. The Coinsurance amounts you must pay for each Covered Benefit are set forth on the “Explanation of Benefits, Copayments & Coinsurance” attached hereto. The In-Network Coinsurance paid by you will apply to only the In-Network Out-of-Pocket Maximum, and does not carry over to the Out-of-Network Out-of-Pocket Maximum. The Out-of-Network Coinsurance paid by you will apply to both the Out-of-Network Out-of-Pocket Maximums and the In-Network Out-of-Pocket Maximum. If you have other than individual coverage, the In-Network and Out-of-Network Coinsurance amounts paid for each person covered under this Contract apply to the In-Network and Out-of-Network Out-of-Pocket Maximums, respectively.
- D. **Additional Payments for Out-of-Network Benefits.** When you receive Covered Benefits from an Out-of-Network Provider, not only must you pay the applicable Copay, Deductible and Coinsurance, but you must also pay the amount, if any, by which the Out-of-Network Provider’s actual charge exceeds the Covered Expense. This means that the total of our coverage and your Deductible and Coinsurance may be less than the Health Professional’s actual charge; you would be liable for that remainder
- E. **Out-of-Pocket Maximum.** The Out-of-Pocket Maximum indicated on the “Explanation of Benefits, Copayments & Coinsurance” attached hereto represents the maximum Out-of-Pocket amount you will pay for Covered Benefits per Calendar Year, except for those actual charges exceeding the Covered Expense for Out-of-Network services as described in Subparagraph “3(D)” above. The Deductible, Copayments and Coinsurance that you pay will be applied against the Out-of-Pocket Maximum.
- F. **Coverage after Satisfying the Out-of-Pocket Maximum and Coinsurance Amounts.** When you have satisfied the Out-of-Pocket Maximums set forth on the “Explanation of Benefits, Copayments & Coinsurance “ attached hereto in any Calendar Year, including payment of any required Coinsurance, we will then provide coverage for 100% of the Covered Expense for the remainder of the Calendar Year. If other than individual coverage applies, when members of the same family covered under this Contract have paid the Out-of-Pocket Maximums in any Calendar Year, including payment of any required Coinsurance, we will provide coverage for 100% of the Covered Expense for the balance of the Calendar Year. You will remain responsible for any actual charges of an Out-of-Network Provider that are in excess of the covered Expense.

## **Section D: Services and Benefits**

This Section explains the Covered Benefits to which you may be entitled under this Contract. We strongly recommend that you read through this entire Section so that you may understand what Covered Benefits are to be provided under this Contract. Please be sure to check the “Prior Justification List” and the “Explanation of Benefits, Copayments & Coinsurance” attached to this Contract for complete Covered Benefit details, including any requirements for Prior Justification and expenses for which you may be responsible. As explained in Section C: Medically Necessary Services; Cost Sharing Expense., only services: 1) that are Medically Necessary; 2) have received the proper Prior Justification (if required); 3) for which you have satisfied all Cost Sharing Expenses; and 4) which are described in this Contract will be covered.

### **1. Health Professional Services**

The following services are covered when provided by a Health Professional, unless otherwise excluded under this Contract.

#### **A. Office Visits**

Coverage will be provided for services for the prevention, diagnosis, and treatment of illness or injury when provided in the medical office of a Health Professional's office, unless otherwise specified under this Certificate. Coverage includes the following:

- (1) Preventative Health Services.
  - a. Adult Physicals. We will provide coverage for periodic adult routine physical examinations in accordance with a schedule based on national coverage determinations, not to exceed two (2) examinations per Member per Calendar Year.
  - b. Well Child Visits and Immunizations through age eighteen (18). We will provide coverage for well child visits in accordance with the schedule recommended by the American Academy of Pediatrics . We will also cover childhood immunizations recommended by the Advisory Committee on Immunization Practices, in accordance with their recommended schedule. We will cover services typically provided in conjunction with a well child visit. Such services include at least: complete medical histories; 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.
  - c. Adult Immunizations age nineteen (19) and over. We will provide coverage for adult immunizations when Medically Necessary in accordance with prevailing medical standards.
- (2) Other Health Services.
  - a. Laboratory and Pathology Services. We will provide coverage for diagnostic and routine laboratory and pathology services.
  - b. Vision Examinations. We will provide coverage for diagnostic and routine vision examinations.

- c. Hearing Examinations. We will provide coverage for diagnostic hearing examinations to determine disease or injury to the ear.
- d. Office Consultation. We will provide coverage for consultations billed by a Health professional. A consultation is professional advice given by a physician to your attending physician upon request of your attending physician.
- e. Home Visits. Home visits provided by a Health Professional when deemed Medically Necessary by the nature of the illness or injury.

**B. Inpatient and Outpatient Health Professional Consultation Services.**

A consultation is professional advice given by a Health Professional to your attending physician upon request of your attending physician. We will provide coverage for consultations billed by a Health Professional subject to the following limitations:

- (1) The physician who is called in must be a specialist in your illness or disease;
- (2) The consultation takes place while you are a registered bed patient in a Facility;
- (3) The consultation is not required by the rules or regulations of the Facility;
- (4) The consulting physician does not thereafter render care or treatment to you;
- (5) The consulting physician enters a written report in your Facility records; and
- (6) Payment will be made for only one consultation during any one day unless a separate diagnosis exists.

**C. Surgical Care.**

We will provide coverage for surgical care performed in the Health Professional's office. This includes operative procedures for the treatment of disease or injury. It includes any pre- and post-operative care usually rendered in connection with such procedures. Pre-operative care includes any pre-operative examination that results in a decision to operate. Surgical care also includes endoscopic procedures and the care of fractures and dislocations of bones. For purposes of this Certificate, Surgical Care also includes plastic and reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or when we determine there is a congenital disease or anomaly which has caused a functional defect. We will provide coverage for surgical services, including all stages of reconstructive surgery, on a breast upon which a mastectomy has been performed. We will also provide coverage for reconstructive surgical procedures on the other breast to produce a symmetrical appearance. Coverage will be provided for all such services rendered in the manner determined appropriate by you and your Health Professional.

**D. Additional Surgical Opinions.**

We will provide coverage for a second opinion with respect to proposed surgery, subject to the following conditions:

- (1) You seek the second surgical opinion after your surgeon determines your need for surgery; and
- (2) The second surgical opinion is rendered by a physician 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; and

- (3) 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 Certificate if such surgery was performed; and
- (4) You are examined in person by the physician rendering the second surgical opinion; and
- (5) The specialist who renders the opinion does not also perform the surgery.
- (6) We will provide coverage for a third surgical opinion if the first two opinions do not agree. These rules also apply to the third surgical opinion.

**E. Second Opinions for Cancer.**

We will provide coverage for a second opinion for the treatment of cancer which is arranged by a Health Professional and which is made by an appropriate Health Professional, which includes, but is not limited to, a specialist affiliated with a specialty care center for the treatment of cancer, in the event of:

- (1) A positive or negative diagnosis of cancer; or
- (2) A recurrence of cancer; or
- (3) A recommendation of a course of treatment for cancer.

Second opinions for the treatment of cancer must be arranged by a Health Professional. If you are referred to an Out-of-Network Health Professional for your second opinion, the cost to you will be the same as if the benefit were received in network.

**F. Allergy Testing and Treatment.**

We will provide coverage for allergy testing that includes injections and tests to determine the nature of allergies. Allergy treatment includes desensitization treatments to alleviate allergies, including test or treatment materials.

**G. Anesthesia Services.**

We will provide coverage for the administration of necessary anesthesia and related procedures in connection with a covered surgical service. The administration and related procedures must be done by a Health Professional other than the Health Professional performing the surgery or an assistant. We will not provide coverage for the administration of anesthesia for a procedure not covered by this Certificate.

**H. Bone Density Testing.**

We will cover bone mineral density measurements and tests for the detection of osteoporosis. We will apply our standards and guidelines that are consistent with the criteria of the federal Medicare program or the National Institutes of Health ("NIH") to determine appropriate coverage for bone density testing under this paragraph. Coverage will be provided for tests covered under Medicare or consistent with the NIH criteria including, as consistent with such criteria, dual-energy x-ray absorptiometry. When consistent with the Medicare or NIH criteria, coverage, at a minimum, will be provided for those Members:

- (1) Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- (2) With symptoms or conditions indicative of the presence, or a significant risk, of osteoporosis; or
- (3) On a prescribed drug regimen posing a significant risk of osteoporosis; or
- (4) With lifestyle factors to the degree of posing a significant risk of osteoporosis; or
- (5) With such age, gender and/or physiological characteristics that pose a significant risk of osteoporosis.

**I. Chiropractic Services.**

We will provide coverage for services rendered in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Services must be rendered by a provider licensed to provide such services.

**J. Covered Therapies.**

We will provide coverage for related rehabilitative physical therapy and physical, occupational and speech therapy when services are rendered by a licensed physical therapist, occupational therapist or speech language pathologist or audiologist and when we determine that your condition is subject to significant clinical improvement through relatively short-term therapy. Rehabilitation therapy is therapy that results in significant clinical improvement and is a Covered Benefit. Maintenance therapy is therapy for a chronic condition(s) that does not result in significant clinical improvement; it 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).

**K. Dialysis.**

We will provide coverage for hemodialysis and peritoneal treatments of an acute or chronic kidney ailment.

**L. Gynecological Services.**

We will provide coverage for gynecology visits, including coverage for two screenings per Calendar Year for cervical cancer and its precursor. The screening may be provided in the outpatient department of a Facility or in a Health Professional's office pursuant to this Section. Cervical cytology screening shall mean 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.

**M. Mammography Screenings.**

We will provide coverage for mammography screenings for occult breast cancer. A "mammography screening" means an x-ray examination of the breast using dedicated equipment, including x-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose of less than 0.5 rem per view per

breast. The screenings may be provided in a Health Professional's office under this Section or in the outpatient department of a Facility. Routine mammography screenings are subject to the following aggregate limitations.

- (1) **Women at Risk.** We will provide coverage for mammograms for women of any age who have a prior history of breast cancer or who have a first degree relative (such as a child, parent or sibling) or a grandparent who has a prior history of breast cancer, if the mammogram is recommended by a physician.
- (2) **Women 35 through 39 Years of Age.** We will provide coverage for one baseline mammogram for women thirty-five (35) through thirty-nine (39) years of age.
- (3) **Women 40 Years of Age and Older.** We will provide one routine mammogram in each Calendar Year for women forty (40) years of age and older.

**N. Radiation Therapy and Chemotherapy.**

We will provide coverage for radiation therapy and chemotherapy.

**O. Screenings For Prostate Cancer.**

We will provide coverage for diagnostic screenings for prostate cancer when prescribed by a Health Professional. A standard diagnostic exam includes, but is not limited to, a digital rectal exam and a prostate specific antigen (PSA) test. Our coverage for prostate screenings shall be subject to the following limitations:

- (1) **Men with a Prior History of Prostate Cancer.** We will provide coverage for standard diagnostic testing for men of any age who have had a prior history of prostate cancer.
- (2) **Men at Risk.** We will provide coverage for one standard diagnostic exam in each Calendar Year for men over the age of 40 who have a family history of prostate cancer or who have other risk factors for prostate cancer.
- (3) **Men 50 Years of Age or Older.** We will provide coverage for one standard diagnostic exam in each Calendar Year for men 50 years of age and older.

**P. X-ray, Diagnostic Imaging Examinations and Diagnostic Radioactive Isotope Procedures.**

Subject to the provisions below, we will provide coverage for the professional component of x-ray examinations; radioactive isotope; ultrasound; CAT scan; and magnetic resonance imaging ("MRI") procedures rendered and billed by a Health Professional. We will provide coverage for a CAT scan (computerized axial tomography) or for any other radiation imagery procedure if it is performed by a Health Professional in a Facility and the installation of the equipment required for the CAT scan or other procedure has been approved by law. If the CAT scan or other procedure is performed in New York State, the installation of the equipment must have been approved under the New York State Public Health Law. If it is performed outside New York State, the installation of the equipment must have the approval of a comparable state authority. If the CAT scan or other procedure is performed in a Health Professional's office, we will provide coverage for the CAT scan or other procedure only if the New York State Public Health Law provides an approval procedure for such a location and only if the installation of the equipment where you receive the service has been approved under that procedure.

## **2. Emergency Care, Urgent Care and Ambulance Services.**

**Please be sure to check the “Prior Justification List” and the “Explanation of Benefits, Copayments & Coinsurance” attached to this Contract for complete Covered Benefit details, including any requirements for Prior Justification and expenses for which you may be responsible.**

### **A. Emergency Care.**

You are not required to obtain prior approval before seeking Emergency Services for an Emergency Condition. In the event that you are faced with an Emergency Condition, you should go directly to the emergency room. If you are not sure if your condition is an emergency you should contact your Health Professional and seek medical attention as quickly as possible. Examples of Emergency Conditions are heart attacks, poisoning and multiple traumas. Examples of conditions not ordinarily considered to be Emergency Conditions are head colds, minor cuts and bruises, muscle strain or hemorrhoids. An 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, which a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- (1) 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
- (2) Serious impairment to such person’s bodily functions; or
- (3) Serious dysfunction of any bodily organ or part of such person; or
- (4) Serious disfigurement of such persons.

### **B. Eligibility for Benefits.**

We will provide coverage for care at the emergency room of an In-Network Provider or Out-of-Network Provider if your illness or condition is considered an Emergency Condition. We will provide coverage for medical visits of Health Professionals who are not Facility employees or interns to treat an Emergency Condition in an emergency room. When you make visits to the emergency room for a condition that is not an Emergency Condition as defined above, you may be liable for the entire charge for the visit including all associated charges such as, but not limited to, x-ray, laboratory services and medication expenses.

### **C. Payment for a Health Professional’s Hospital Emergency Room Visit.**

We will provide coverage for visits of a Health Professional if your illness or condition is considered an Emergency Condition. We will not provide coverage for medical visits by Facility employees or interns, even if they are Health Professionals.

### **D. Urgent Care in an Urgent Care Center.**

We will provide coverage for Urgent Services as defined in the Definition section of this Certificate if the Health Professional determines Urgent Care is required but cannot see the Member. The Health Professional can refer the Member to the

nearest participating Urgent Care Center for treatment. These services are covered only if the Health Professional referred the Member to the Urgent Care Center.

**E. If you require Urgent Care while Out-of-Network, you must first call your Health Professional. Urgent Care rendered by non-Participating Providers and/or while Out-of-Network must be Pre-Certified by your Health Professional Ambulance Services**

We will provide Coverage for Medically Necessary ambulance services provided by a Hospital, professional or licensed ambulance service for the following:

- (1) Prehospital Emergency Services and Transportation:
  - a. Prehospital emergency services means the prompt evaluation and treatment of an emergency condition as defined in the Introduction and Definitions section of this Certificate.
  - b. Prehospital Emergency Transportation means non-air- borne transportation of the patient to a hospital due to an emergency condition as defined in the Introduction and “Definitions” 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.
  - c. Medically necessary transport between facilities
  - d. For non-emergency transport only when Prior Justified
  - e. When ordered by an employer, school or public safety official, or when you are not in a position to refuse the service.

### 3. Maternity and Family Planning Services.

Please be sure to check the “Prior Justification List” and the “Explanation of Benefits, Copayments & Coinsurance” attached to this Contract for complete Covered Benefit details, including any requirements for Prior Justification and expenses for which you may be responsible.

#### A. Maternity Benefits.

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 Certificate, including the following:

- (1) At least forty-eight (48) hours following a normal delivery and at least ninety-six (96) hours following a caesarean section delivery, regardless of whether such care is Medically Necessary.
- (2) Parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments.
- (3) Additional days of such care that we determine are Medically Necessary.
- (4) Anesthesia. We will provide coverage for anesthesia during delivery.

In the event the mother elects to leave the Hospital and requests a home care visit before the end of the forty-eight (48) hour or ninety-six (96) hour minimum coverage period, we will provide coverage of the home care visit furnished by the type of home care agency described in this Certificate. The home care visit will be provided within twenty-four (24) hours after the mother’s discharge, or the time of the mother’s request, whichever is later. Our coverage of this home care visit shall not be subject to the Copayment, Coinsurance or Deductible amounts described in the “Explanation of Benefits, Copayments and Coinsurance” attached to this Certificate.

#### B. Infertility Services.

We will provide coverage for Medically Necessary inpatient Hospital care or outpatient Facility care in connection with infertility treatment services provided by a Health Professional. We will provide coverage for Medically Necessary services for the diagnosis and treatment of infertility subject to the following conditions:

- (1) **Infertility Defined.** For the purposes of this paragraph, infertility has the meaning set forth in the regulations of the New York State Insurance Department. The determination of “infertility “ shall be in accordance with the standards and guidelines established and adopted by the American Society for Reproductive Medicine. In general, infertility means the inability of a couple to achieve a pregnancy after twelve (12) months of unprotected intercourse.
- (2) **Coverage Provided for Individuals 21 to 44 Years of Age.** The benefits provided by this paragraph are available only to Members covered under this Certificate who are between the ages of twenty-one (21) and forty-four (44) as of the date the services are rendered.
- (3) **Coverage Only Provided for Appropriate Candidates.** An Appropriate Candidate is an individual within the age group described in the “Services and

Benefits” section, sub-section “Maternity and Family Planning Services”, paragraph (B)(2), and who is determined to be an Appropriate Candidate by the treating physician, in accordance with the standards and guidelines established and adopted by the New York State Insurance Department by regulation.

- (4) **Covered Services.** Subject to the other provisions of this paragraph and your Certificate, we will provide benefits under this paragraph for:
  - a. Medical and surgical procedures, such as artificial insemination, intrauterine insemination, and dilation and curettage (“D&C”), that would correct malformation, disease or dysfunction resulting in infertility; and
  - b. Services in relation to diagnostic tests and procedures necessary:
    - I To determine infertility; or
    - II In connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered by this paragraph are:
      - (i.) Hysterosalpingogram;
      - (ii.) Hysteroscopy;
      - (iii.) Endometrial biopsy;
      - (iv.) Laparoscopy;
      - (v.) Sono-hysterogram;
      - (vi.) Post-coital tests;
      - (vii.) Testis biopsy;
      - (viii.) Semen analysis;
      - (ix.) Blood tests;
      - (x.) Ultrasound; and
      - (xi.) Other Medically Necessary diagnostic tests and procedures, unless excluded by law.
- (5) **Plan of Care Required.** All services covered under this paragraph must be prescribed by a physician as part of a “plan of care.” The plan of care must be in writing, and must be available for review by us. Services or procedures that are inconsistent with or not included in the plan of care will not be covered.
- (6) **Services Must be Received from Eligible Providers.** Services covered by this paragraph must be received from “Eligible Providers” as determined by us in accordance with applicable regulations of the New York State Insurance Department. In general, an Eligible Provider is defined as a Health Professional who meets the required education, training, experience and other standards established and adopted by the American Society for Reproductive Medicine.
- (7) **Excluded Services.** We will not pay benefits for any services related to or in connection with:
  - c. In-Vitro Fertilization;
  - d. Gamete Intra-Fallopian Transfer (GIFT);
  - e. Zygote Intra-Fallopian Transfer (ZIFT);
  - f. Reversal of elective sterilizations, including vasectomies and tubal ligations;

- g. Sex change procedures;
  - h. Cloning;
  - i. Sperm banking and donor fees associated with artificial insemination or other procedures;
  - j. Other procedures or categories of procedures excluded by statute.
- (8) **Experimental Procedures Not Covered.** We do not cover services or procedures that we determine to be experimental, according to standards and guidelines that are no less favorable than those established and adopted by the American Society for Reproductive Medicine.

You may appeal our determination that a service or procedure is experimental to an external appeal agent as described in this Certificate.

**C. Family Planning Services.**

We will provide coverage for the following:

- (1) Pregnancy terminations (abortions) are covered when authorized by a Health Professional and performed in accordance with the laws of the State of New York.
- (2) A Member's first voluntary sterilization is a Covered Benefit. Reversals and subsequent sterilizations are not covered.

#### **4. Home Health Care, Hospice Care and Home Infusion Services.**

**Please be sure to check the “Prior Justification List” and the “Explanation of Benefits, Copayments & Coinsurance” attached to this Contract for complete Covered Benefit details, including any requirements for Prior Justification and expenses for which you may be responsible.**

##### **A. Home Care.**

We will provide for Home Health Care, provided by a Home Health Agency when determined Medically Necessary by your Health Professional. If operating outside of New York State, the home health agency or home care services agency must be qualified by Medicare.

##### **B. Home Health Care Eligibility.**

We will provide coverage for home care only if all the following conditions are met:

- (1) A home care treatment plan is established and approved in writing by your Health Professional;
- (2) The treatment is provided by a certified or licensed home health agency or home care services agency, and you apply through your Health Professional to the Home Health Agency or home care services agency with supporting evidence of your need and eligibility for home care; and
- (3) The home care is related to an illness or injury for which you were hospitalized or for which you would have been hospitalized or confined in a Skilled Nursing Facility. This home care must be Medically Necessary at a Skill or acute level of care.

You will not be entitled to coverage of any home care after the date we determine you are no longer eligible for such services.

##### **C. Home Health Care Benefits.**

We will provide coverage for the following services:

- (1) Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.);
- (2) Part-time or intermittent home health aide services which consist primarily of rendering direct care to you, the patient;
- (3) Physical, occupational or speech therapy if provided by the home health service or agency; and
- (4) Medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a certified 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.

For purposes of this paragraph, “part-time or intermittent” means no more than thirty-five (35) hours per week.

##### **D. Home Health Care Treatment Plan: Failure to Comply.**

If you fail or are unable to comply with the home care treatment plan, we may terminate benefits for your plan of home care.

#### **E. Home Health Care: Number of Visits.**

We will provide coverage for the amount of home care days indicated on your "Explanation of Benefits, Copayments & Coinsurance" attached hereto in a Calendar Year.

#### **F. Hospice Care: Eligibility for Benefits.**

Terminally ill Members are eligible for hospice care when 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.

- (1) A Member is considered terminally ill if the Member's attending health care practitioner estimates that the Member has a life expectancy of six (6) months or less (with no hope of reversal of the primary disease).
- (2) Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.

All care must be provided by a certified hospice organization. Appropriate care of a Member must be coordinated through the Member's attending health care practitioner, the medical director of the facility and our Medical Director.

#### **G. Hospice Organization.**

In New York State we will provide coverage only for hospice care provided by a hospice organization which has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the hospice organization must have an operating certificate issued under criteria similar to those used in New York by a state agency in the state where the hospice care is provided, or it must be approved by Medicare.

#### **H. Hospice Care Benefits.**

Inpatient and Outpatient. Hospice benefits are non-aggressive services provided to maintain the comfort, quality and dignity of life to the terminally ill patient. Hospice care coverage includes: inpatient care provided by the hospice organization, either in a designated hospice unit or in a Hospital; day care services provided by the hospice organization; home care and outpatient services when provided and billed through the hospice. The services may include at least the following:

- (1) Intermittent nursing care by an R.N., L.P.N. or home health aide;
- (2) Medical care provided by a physician;
- (3) Physical therapy;
- (4) Speech therapy;
- (5) Respiratory therapy;
- (6) Social Services;
- (7) Nutritional services;
- (8) Laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms;
- (9) Medical supplies;
- (10) Durable medical equipment

- (11) Bereavement counseling up to five (5) visits provided for Members who are family members before or after the death of the Member; and
- (12) Drugs and medications that require a prescription by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary. We will not provide coverage when the drug or medication is of an experimental nature.

**I. Hospice Care: Number of Visits.**

We will provide coverage for the amount of hospice care days indicated on your "Explanation of Benefits, Copayments & Coinsurance" attached hereto in a Calendar Year. Each day you receive care from or through the hospice counts as a day of hospice care.

**J. Home Infusion Services.**

We will provide coverage for home infusion services and Medically Necessary Durable Medical Equipment required for the administration of the infused drug(s) when provided by a Health Professional.

## 5. Inpatient Care

**Please be sure to check the “Prior Justification List” and the “Explanation of Benefits, Copayments & Coinsurance” attached to this Contract for complete Covered Benefit details, including any requirements for Prior Justification and expenses for which you may be responsible.**

We will provide coverage when it is Medically Necessary for you to stay in a Facility for acute medical, surgical care or accidental injury. You must be a registered bed patient, the services must be given to you by an employee of the Facility, the Facility must bill for the services and the Facility must retain the money collected for the services. There is no limit to the number of inpatient days, except where the services are for mental health inpatient services, alcohol and chemical dependency inpatient services and Skilled Nursing Facility services as indicated in the “**Explanation of Benefits, Copayments & Coinsurance**” attached hereto. Our coverage for Inpatient Care includes the following Services:

### **A. Room.**

We will provide coverage for a semi-private room, board and the use of operating and delivery rooms and related facilities.

### **B. Pre-Admission Testing.**

Coverage is provided for Pre-admission testing and tests that must be performed before you are admitted to a Hospital for surgery and are ordered by a Health Professional. The tests must meet all the following conditions:

- (1) They must be necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; and
- (2) You must have a reservation for the Facility bed and/or the operating room before the tests are given; and
- (3) You must be physically present at the Facility when the tests are given; and
- (4) The surgery must actually take place within seven (7) days after the tests are performed.

### **C. Inpatient Consultation.**

A consultation is professional advice given by a physician to your attending physician upon request of your attending physician. We will provide coverage for consultations billed by a physician, subject to the following limitations:

- (1) The physician who is called in is a specialist in your illness or disease;
- (2) The consultations take place while you are a registered bed patient in a Facility;
- (3) The consultation is not required by the rules or regulations of the Facility;
- (4) The consulting physician does not thereafter render care or treatment to you;
- (5) The consulting physician enters a written report in your Facility records; and
- (6) Payment will be made for only one consultation during any one day unless a separate diagnosis exists.

**D. Surgical Care.**

We will provide coverage for surgical care performed in the Facility. This includes operative procedures for the treatment of disease or injury. It includes any pre- and post-operative care usually rendered in connection with such procedures. Pre-operative care includes any pre-operative examination that results in a decision to operate. Surgical care also includes endoscopic procedures and the care of fractures and dislocations of bones. For purposes of this Certificate, Surgical Care also includes plastic and reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or when we determine there is a congenital disease or anomaly which has caused a functional defect.

**E. Additional Surgical Opinions.**

We will provide coverage for a second opinion with respect to proposed surgery under the following conditions:

- (1) You seek the second surgical opinion after your surgeon determines your need for surgery; and
- (2) The second surgical opinion is rendered by a physician 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; and
- (3) 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 Certificate if such surgery was performed; and
- (4) You are examined in person by the physician rendering the second surgical opinion; and
- (5) The specialist who renders the opinion does not also perform the surgery.

We will provide coverage for a third surgical opinion if the first two opinions do not agree. The rule described above also applies to the third surgical opinion.

**F. Second Opinions for Cancer.**

We will provide coverage for a second opinion by an appropriate Health Professional in the event of:

- (1) A positive or negative diagnosis of cancer; or
- (2) A recurrence of cancer; or
- (3) A recommendation of a course of treatment for cancer.

An appropriate Health Professional 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 must be arranged by a Health Professional. If you are referred to an Out-of-Network Health Professional for your second opinion, the cost to you will be the same as if the benefit were received in-network.

**G. Anesthesia Services.**

We will provide coverage for the administration of necessary anesthesia and related procedures in connection with a covered surgical service. The administration and related procedures must be done by a Health Professional other than the Health Professional performing the surgery or an assistant. We will not provide coverage for the administration of anesthesia for a procedure not covered by this Certificate.

**H. Chemical Abuse/ Chemical Dependence Services.**

See Section D: Services and Benefits, paragraph 9.

**I. Continuous Confinement.**

If you are readmitted as an inpatient to either a Hospital or Skilled Nursing Facility within ninety (90) days of discharge for the same or similar diagnosis, you will not be responsible for another inpatient Copayment.

**J. Covered Therapies.**

We will provide coverage for related rehabilitative physical therapy and physical, occupational and speech therapy when services are rendered by a licensed physical therapist, occupational therapist or speech language pathologist or audiologist and when we determine that your condition is subject to significant clinical improvement through relatively short-term therapy. Rehabilitation therapy is therapy that results in significant clinical improvement and is a Covered Benefit. Maintenance therapy is therapy for a chronic condition(s) and that does not result in significant clinical improvement; it 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).

**K. Dialysis.**

We will provide coverage for hemodialysis and peritoneal treatments of an acute or chronic kidney ailment.

**L. Infertility Treatment Services.**

Please see subsection "Maternity and Family Planning Services" found in section "Services and Benefits" in this Certificate.

**M. Laboratory and Pathology Services.**

We will provide coverage for diagnostic and routine laboratory and pathology services.

**N. Mastectomy Care.**

We will provide coverage including coverage of an inpatient Hospital stay following a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer. The length of stay will be determined by you and your Health Professional. We will also provide coverage for prostheses and treatment of physical complications of the mastectomy, including lymphedemas. We will provide coverage for surgical services, including all stages of reconstructive surgery on a breast on which a mastectomy has been performed. We will also provide coverage for reconstructive surgical procedures on the other breast to produce a symmetrical appearance.

**O. Maternity and Family Planning Services.**

Please see subsection "Maternity and Family Planning Services" found in section "Services and Benefits" in this Certificate.

**P. Mental Health Services.**

Please see sub-section "Mental Health Services" under the "Services and Benefits" section of this Certificate for a more detailed explanation of this benefit.

**Q. Radiation Therapy and Chemotherapy.**

We will provide coverage for radiation therapy and chemotherapy.

**R. Skilled Services in a Skilled Nursing Facility or Hospital.**

We will provide coverage for inpatient semi-private Skilled Services and accommodations when determined to be Medically Necessary, subject to the following:

- (1) The Skilled Services must be temporary in nature. Skilled Rehabilitation services must lead to rehabilitation and increased ability to function within a reasonable period of time.
- (2) 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.
- (3) 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.

**S. Services Not Covered.**

We will not provide coverage for the following:

- (1) Additional charges for special duty nurses;
- (2) Private room, unless it is Medically Necessary for you to occupy a private room. If you occupy a private room in a Facility and we determine that a private room is not Medically Necessary, our coverage will be based upon the Facility's maximum semi-private room charge. You will have to pay the difference between our coverage and the charge for the private room;
- (3) Non-medical items, such as telephone or television rental;
- (4) Medications, supplies, and equipment which you take home from the Facility; or
- (5) Custodial care. Please see the sub-section "Custodial Care" found in the "Exclusions" section of this Certificate.
- (6) Outpatient and Ambulatory Care.

**T. X-ray, Diagnostic Imaging Examinations and Diagnostic Radioactive Isotope Procedures.**

Subject to the provisions below, we will provide coverage for the professional component of x-ray examinations; radioactive isotope; ultrasound; CAT scan; and magnetic resonance imaging (MRI) procedures rendered and billed by a Health Professional. We will provide coverage for a CAT scan (computerized axial tomography) or for any other radiation imagery procedure if it is performed by a Health Professional in a Facility and the installation of the equipment required for the CAT scan or other procedure has been approved by law. We will not provide benefits for the cost of referrals to radiology facilities, pharmacies or laboratories, which are prohibited under N.Y. Pub. Health Law § 238-a(1).

## **6. Outpatient and Ambulatory Care**

**For every Service, please be sure to check the “Prior Justification List” and the “Explanation of Benefits, Copayments & Coinsurance” attached to this Contract for complete Covered Benefit details, including any requirements for Prior Justification and expenses for which you may be responsible.**

We will provide coverage for the same services we would cover if you were an inpatient, in connection with the care described below, when given to you in the outpatient department of a Facility. As in the case of inpatient care, the service must be given by an employee of the Facility; the Facility must bill for the service; and the Facility must retain the money collected for the service.

### **A. Pre-Admission Testing.**

Coverage is provided for Pre-admission testing and tests that must be performed before you are admitted to a Hospital for surgery and are ordered by a Health Professional. The tests must meet all the following conditions:

- (1) They must be necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; and
- (2) You must have a reservation for the Facility bed and/or the operating room before the tests are given; and
- (3) You must be physically present at the Facility when the tests are given; and
- (4) The surgery must actually take place within seven (7) days after the tests are performed.

### **B. Surgical Care.**

We will provide coverage for surgical care performed in the Facility. We will only provide coverage if we determine that it was necessary to use the Facility to perform the surgery.

### **C. Surgical Coverage.**

Surgical Coverage includes operative procedures for the treatment of disease or injury. It includes any pre- and post-operative care usually rendered in connection with such procedures. Pre-operative care includes any pre-operative examination that results in a decision to operate. Surgical care also includes endoscopic procedures and the care of fractures and dislocations of bones. For purposes of this Certificate, Surgical Care also includes plastic and reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or when we determine there is a congenital disease or anomaly which has caused a functional defect.

### **D. Additional Surgical Opinions.**

We will provide coverage for a second opinion with respect to proposed surgery under the following conditions:

- (1) You seek the second surgical opinion after your surgeon determines your need for surgery; and

- (2) The second surgical opinion is rendered by a physician 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; and
- (3) 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 Certificate if such surgery was performed; and
- (4) You are examined in person by the physician rendering the second surgical opinion; and
- (5) The specialist who renders the opinion does not also perform the surgery.

We will provide coverage for a third surgical opinion if the first two opinions do not agree. The rule described above also applies to the third surgical opinion.

**E. Second Opinions for Cancer.**

We will provide coverage for a second opinion by an appropriate Health Professional in the event of:

- (1) A positive or negative diagnosis of cancer; or
- (2) A recurrence of cancer; or
- (3) A recommendation of a course of treatment for cancer.

An appropriate Health Professional 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 must be arranged by a Health Professional.

**F. Anesthesia Services.**

We will provide coverage for the administration of necessary anesthesia and related procedures in connection with a covered surgical service. The administration and related procedures must be done by a Health Professional other than the Health Professional performing the surgery or an assistant. We will not provide coverage for the administration of anesthesia for a procedure not covered by this Certificate.

**G. Cardiac Rehabilitation.**

We will provide coverage for Medically Necessary, Phase II cardiac rehabilitation programs on referral by a Health Professional. We will provide coverage for the amount of cardiac rehabilitation days indicated on your "Explanation of Benefits, Copayments & Coinsurance" attached hereto in a Calendar Year.

**H. Chemical Abuse/ Chemical Dependence Services.**

Please see sub-section "Chemical Abuse/ Chemical Dependence" found in the "Services and Benefits" section of this Certificate.

**I. Covered Therapies.**

We will provide coverage for related rehabilitative physical therapy and physical, occupational; and speech therapy when services are rendered by a licensed physical therapist; occupational therapist or speech language pathologist or audiologist and when we determine that your condition is subject to significant clinical improvement through relatively short-term therapy. Therapy is limited to coverage for the treatment of those conditions which are subject to significant clinical improvement within a reasonable period of time. Rehabilitation therapy is therapy

that results in significant clinical improvement and is a Covered Benefit. Maintenance therapy is therapy for a chronic condition(s) and that does not result in significant clinical improvement; it 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).

**J. Dialysis.**

We will provide coverage for hemodialysis and peritoneal treatments of an acute or chronic kidney ailment.

**K. Gynecological Services.**

We will provide coverage for gynecology visits, including coverage for two (2) screenings per Calendar Year for cervical cancer and its precursor. The screenings may be provided in the outpatient department of a Facility or in a Health Professional's office. Cervical cytology screening shall mean 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.

**L. Infertility Treatment Services.**

Please see sub-section "Maternity Care and Family Planning" found in the "Services and Benefits" section of this Certificate.

**M. Laboratory and Pathology Services.**

We will provide coverage for diagnostic and routine laboratory and pathology services.

**N. Mammography Screenings.**

We will provide coverage for mammography screenings for occult breast cancer. The screenings may be provided in the outpatient department of a Facility or in a Health Professional's office. Routine mammography screenings are subject to the following aggregate limitations:

- (1) Women at Risk. We will provide coverage for mammograms for women of any age who have a prior history of breast cancer or who have a first degree relative (such as a child, parent or sibling) or a grandparent who has a prior history of breast cancer, if the mammogram is recommended by a physician.
- (2) Women 35 through 39 Years of Age. We will provide coverage for one baseline mammogram for women thirty-five (35) through thirty-nine (39) years of age.
- (3) Women 40 Years of Age and Older. We will provide one routine mammogram in each Calendar Year for women forty (40) years of age and older.

**O. Mastectomy Care.**

We will provide coverage for the following: a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer. We will also provide coverage for prostheses and treatment of physical complications of the mastectomy, including lymphedemas. We will provide coverage for surgical services, including all stages of reconstructive surgery on a breast on which a mastectomy has been performed. We

will also provide coverage for reconstructive surgical procedures on the other breast to produce a symmetrical appearance.

**P. Maternity and Family Planning Services.**

Please see sub-section "Maternity Care and Family Planning" found in the "Services and Benefits" section of this Certificate.

**Q. Mental Health Services.**

Please see sub-section "Mental Health Services" found in the "Services and Benefits" section of this Certificate.

**R. Radiation Therapy and Chemotherapy.**

We will provide coverage for radiation therapy and chemotherapy.

**S. X-ray, Diagnostic Imaging Examinations and Diagnostic Radioactive Isotope Procedures.**

Subject to the provisions below, we will provide coverage for the professional component of x-ray examinations; radioactive isotope; ultrasound; CAT scan; and magnetic resonance imaging ("MRI") procedures rendered and billed by a Health Professional. We will provide coverage for a CAT scan (computerized axial tomography) or for any other radiation imagery procedure if it is performed by a Health Professional in a Facility and the installation of the equipment required for the CAT scan or other procedure has been approved by law. If the CAT scan or other procedure is performed in New York State, the installation of the equipment must have been approved under the New York State Public Health Law. If it is performed outside New York State, the installation of the equipment must have the approval of a comparable state authority. If the CAT scan or other procedure is performed in a Health Professional's office, we will provide coverage for the CAT scan or other procedure only if the New York State Public Health Law provides an approval procedure for such a location and only if the installation of the equipment where you receive the service has been approved under that procedure.

## **7. Human Organ and Bone Marrow Transplant**

**For every Service, please be sure to check the “Prior Justification List” and the “Explanation of Benefits, Copayments & Coinsurance” attached to this Contract for complete Covered Benefit details, including any requirements for Prior Justification and expenses for which you may be responsible.**

We will provide coverage for all of the benefits otherwise covered under this Contract for organ and bone marrow transplants subject to the following limits:

### **A. Second Opinions Required.**

We may require a second opinion on the Medical Necessity of the proposed organ transplant. We will arrange this second opinion at no cost to you. The second opinion will be rendered by a physician designated by us who is a board-certified specialist and who, by reason of his or her specialty, is an appropriate physician to consider the proposed transplant. We will cover a third opinion by a physician designated by us if the first two opinions do not agree.

### **B. Prior Justification Before You Sign Up for the Transplant List.**

As shown on the “Prior Justification List” attached to this Certificate, all organ transplants must be pre-approved by us. Please refer to sub-section “Prior Justification of Certain Covered Benefits” found in the “Medically Necessary Services and Cost Sharing Expense” section of this Certificate for certain Covered Benefits.

### **C. Coverage in Approved vs. Non-approved Transplant Centers.**

Certain types of organ transplant procedures must be performed in In-Network transplant centers approved by us for the specific transplant procedure being performed in order to receive the maximum benefit. The types of organ transplants which must be performed in an In-Network transplant center are currently bone marrow transplants, cord blood stem cell transplants, liver transplants, heart transplants, lung transplants, heart-lung transplants, multivisceral transplants, small intestine transplants, kidney transplants, pancreas transplants and kidney-pancreas transplants. You may contact us to obtain a list, which we maintain and revise from time to time of approved organ transplant procedures that must be performed by In-Network providers in order to receive the maximum benefit. If you receive one of these types of organ transplants in a transplant center not approved by us for the specific transplant procedure being performed, coverage for care related to that transplant will be subject to the cost-sharing requirements for Out of Network Benefits listed in sub-section “Cost Sharing Expense for Covered Benefits” found in the “Medically Necessary and Cost Sharing Expense” section of this Certificate.

### **D. No Coverage of Experimental or Investigational Organ Transplants.**

We will not provide coverage for any benefits for an organ transplant we determine to be experimental or investigational. We maintain and revise from time to time a list of organ transplant procedures which we determine not to be experimental or investigational and therefore are covered under this Certificate. You may contact us for Prior Justification (Please refer to sub-section “Prior Justification of Certain Covered Benefits” found in the “Medically Necessary Services and Cost Sharing Expense” section of this Certificate) for a particular transplant procedure. Please

refer to sub-section “External Appeal” found in the “General Provisions” section of this Certificate, for your right to an external appeal of our determination that an organ transplant is experimental or investigational.

**E. Recipient Benefits.**

We will provide coverage for a person covered under this Certificate for all of the benefits provided to the recipient of the organ transplant that are otherwise covered under this Certificate when they result from or are directly related to a covered organ or bone marrow transplant.

**F. Coverage For Donor Searches or Screening.**

We will not provide coverage for costs relating to searches or screenings for donors of organs.

**G. Costs of Organ Donor.**

We will provide coverage for the medical services directly related to the donation of an organ for transplantation to a person covered under this Certificate. We will not provide coverage if you are donating an organ for transplantation to a person not covered under this Certificate.

**8. Mental Health Services.**

**For every Service, please be sure to check the “Prior Justification List” and the “Explanation of Benefits, Copayments & Coinsurance” attached to this Contract for complete Covered Benefit details, including any requirements for Prior Justification and expenses for which you may be responsible.**

**A. Mental Health Inpatient Services.**

We will provide coverage for acute mental health services that includes a stay in a semi-private room and related Professional Services, when authorized by your Health Professional and rendered in an appropriate Facility. We will provide coverage for the amount of behavioral health inpatient service days indicated on your “Explanation of Benefits, Copayments & Coinsurance” attached hereto in a Calendar Year

**B. Mental Health Outpatient Services.**

We will provide coverage for evaluation and short-term treatment, for conditions that can be expected to result in significant improvement within a relatively short period of time based on our clinical guidelines.

## **9. Chemical Abuse/ Chemical Dependence Services.**

**For every Service, please be sure to check the “Prior Justification List” and the “Explanation of Benefits, Copayments & Coinsurance” attached to this Contract for complete Covered Benefit details, including any requirements for Prior Justification and expenses for which you may be responsible.**

### **A. Inpatient Detoxification.**

We will provide coverage for active treatment for detoxification needed because of alcohol or chemical dependence. Please check the “Explanation of Benefits, Copayments & Coinsurance” attached to this Certificate for your particular coverage. The coverage includes a stay in a semi-private Hospital room and Professional Services relating to detoxification of alcohol abuse or chemical dependence. This coverage is available only for services rendered in and billed by:

- (1) A Facility in New York State which is certified by the Office of Alcoholism and Substance Abuse Services;
- (2) A program we recognize as a chemical dependence and abuse treatment program; or
- (3) A Facility in another state that we recognize is approved by the Joint Commission on Accreditation of Health Care Organizations as an alcoholism or chemical dependence and abuse treatment program and meets the appropriate state licensing.

### **B. Inpatient Alcohol/Chemical Abuse and Dependency Rehabilitation.**

We will provide coverage for the diagnosis and active treatment for rehabilitation of chemical dependence and abuse. We will provide coverage for a 24-hour live-in program of services in a Facility that is approved by us for the active rehabilitation and treatment of chemical abuse. The program is non-medical and provides rehabilitation and treatment for chemical abuse or dependence in a controlled environment. We will not provide benefits for care in a non-therapeutic residential facility.

### **C. Outpatient Alcohol/Chemical Abuse and Dependency Services.**

We will provide coverage for outpatient visits in a Facility for the diagnosis and treatment of alcohol/chemical dependence. Each individual visit must consist of at least one of the following: individual or group alcohol/chemical dependence counseling; activity therapy; and diagnostic evaluations by a Health Professional to determine the nature and extent of your illness or disability. We will not provide coverage for visits that consist primarily of participation in programs of a social, recreational, or companionship nature.

We will provide coverage for up to an aggregate of sixty (60) outpatient visits per Member each Calendar Year. Up to twenty (20) of the sixty (60) visits may be used for family therapy. Family therapy consists of visits that include members of your family in order for them to understand the illness and to play a meaningful role in the family member’s recovery. Our coverage of a family visit will be the same regardless of the number of family members who attend the family visit. The family therapy visits may be used only by people who are covered under this Certificate. We will provide coverage for the amount of outpatient days indicated on your “Explanation of Benefits, Copayments & Coinsurance” attached hereto in a Calendar Year

## 10. Additional Benefits

**For every Service, please be sure to check the “Prior Justification List” and the “Explanation of Benefits, Copayments & Coinsurance” attached to this Contract for complete Covered Benefit details, including any requirements for Prior Justification and expenses for which you may be responsible.**

### A. Acupuncture.

We will provide coverage for the amount of acupuncture treatments indicated on your “Explanation of Benefits, Copayments & Coinsurance” attached hereto in a Calendar Year. Services must be rendered by a Health Professional licensed to provide such services; and determined by us by our Medical Director or designee, to be Medically Necessary.

### B. Dental Care.

All Dental Care must be Prior Justified unless provided in an emergency setting. We will not provide coverage for any service or care (including anesthesia and inpatient stays) for treatment of the teeth, gums, or structures supporting the teeth; or any form of dental surgery; regardless of the reason(s) that the service or care is necessary. For example, we will not provide coverage for x-rays, fillings, extractions, braces, prosthetics, correction of impactions, treatments for gum disease, therapy or other treatments related to dental temporomandibular joint (TMJ) disorder or dental oral surgery. We will however, provide coverage for medical treatment that is directly related to an injury or accident involving the jaw or other bone structures adjoining the teeth, provided that the treatment is Prior Justified. In addition, we will provide the benefits set forth in this certificate for service and care for treatment of sound, natural teeth provided within twelve months of an accidental injury and provided that you are a Member when services are rendered. We do not consider an injury to a tooth caused by chewing or biting to be an accidental injury. We will also provide the benefits set forth in this Certificate for service and care that we determine is Medically Necessary for treatment due to a congenital disease or anomaly. For purposes of this paragraph, “congenital” means present at birth. We will cover institutional provider services for dental care when we determine there is an underlying medical condition requiring these services.

### C. Diabetic Coverage.

Coverage for the treatment of diabetes includes the following equipment and supplies for the treatment of diabetes which we determine to be Medically Necessary and when prescribed or recommended by your Health Professional who is legally authorized to prescribe under Title 8 of the New York State Education Law (“Authorized Medical Personnel”):

- (1) 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

- (2) Professional Services Consisting of Diabetes Self-Management Education. If you are diabetic, coverage will be provided for education to ensure you are trained in the proper self-management and treatment of your condition, including information on proper diets. Such education will be limited to visits when there is a diagnosis of diabetes, where a Health Professional diagnoses a significant change in your symptoms or conditions necessitating changes in self-management, or where reeducation or refresher education is necessary. Education provided by certified diabetes educators, certified nutritionists, certified dietitians, or registered dietitians will be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet will also include home visits when Medically Necessary.
- (3) Insulin and Oral Agents for Controlling Blood Sugar. We will provide coverage for the amount of insulin and oral agents indicated on your "Explanation of Benefits, Copayments & Coinsurance" attached hereto.
- (4) Repair, replacement and adjustment of the above diabetic equipment and supplies are covered when made necessary by normal wear and tear. However, repair and replacement of diabetic equipment and supplies made necessary because of loss or damage caused by misuse or mistreatment are not covered.
- (5) We will also pay for disposable syringes and needles used solely for the injection of insulin. We will not pay for reusable syringes and needles or multi-use disposable syringes or needles.

**D. Durable Medical Equipment.**

Coverage is provided for the rental, purchase, repair or maintenance of durable medical equipment. We will provide coverage for durable medical equipment that your Health Professional or other licensed/authorized provider and our Medical Director determines to be Medically Necessary. We will determine whether the item should be purchased or rented. Please refer to your "Explanation of Benefits, Copayments & Coinsurance" attached hereto for cost limitations. The durable medical equipment must meet all of the following criteria:

- (1) Meet Medicare Guidelines and must be provided as a result of Medical Necessity;
- (2) Be the kind generally used for a medical purpose, not for your comfort and/or convenience;
- (3) Be able to withstand repeated use;
- (4) Be appropriate for use in the Member's home;
- (5) Examples of covered equipment include but are not limited to: crutches, wheelchairs of a Medically Necessary type, special hospital bed, or home dialysis unit.
- (6) Examples of equipment NOT covered include but are not limited to: air conditioners, humidifiers, dehumidifiers, air purifiers, sauna baths, whirlpool baths, Jacuzzi, all terrain vehicles (ATV's), exercise equipment, environmental control systems or medical supplies.
- (7) Be prescribed by a Health Professional (and, in some cases, Pre-Certified and/or Prior-Justified by you);

- (8) Repair, rental, replacement and maintenance of authorized DME will be covered; however, coverage is limited to normal wear, use and body growth/change. There is no coverage for equipment that is under warranty or equipment that has been misused, abused, lost, damaged by natural disaster, stolen or cared for improperly, unless approved in advance by our Medical Director.
- (9) Benefits are provided only for the basic item and any Medically Necessary special features prescribed by your Health Professional and approved by our Medical Director. There is no coverage for the additional costs of deluxe equipment not otherwise Medically Necessary, service charges, routine maintenance or shipping charges.

**E. HealthDollars.**

We will provide HealthDollars Benefits in the amount of fifty (50) HealthDollars. 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.

**F. Medical Treatment of Obesity.**

Coverage is provided for participation in a multidisciplinary weight management program for chronically obese members whose lives are endangered due to excessive weight. Services must be Prior Justified. Contracted In-Network programs are available to Members. For programs other than our participating programs coverage must meet the following criteria:

- (1) Services must include nutritional counseling, exercise instruction and behavioral modification. These services are to be delivered by a licensed registered dietician, a certified personal trainer or exercise physiologist and a licensed behavioral health specialist or social worker.
- (2) Individualized screening and assessments are to be provided by all specialties.
- (3) The program must include two phases of weight loss: An intensive weight loss phase, wherein the participant is intended to lose 10% of their body weight within a 4-6 month period, and a maintenance phase, lasting an additional 2-6 months, wherein the participant is actively involved in behavioral modification classes.
- (4) The multidisciplinary weight management program will conduct individual or group sessions weekly or biweekly. Group sessions are not meant to replace the individualized sessions the participant is to receive from the program's specialists. A member can attend both a group session and an individualized session in the same week.

The following are not covered benefits: The cost of supplies or food supplements provided by the program, informational/ educational or training materials required by the program, and the cost of phone contacts or internet contacts. Preferred Care will not cover more than 12 months of a multidisciplinary weight management program. Services are limited to one (1) program per Member per lifetime.

## **G. Orthotics.**

We will provide coverage for orthotic devices as defined by Medicare. Custom-made orthopedic shoes are covered if they are an integral part of a leg brace or are therapeutic shoes for a diabetic Member prescribed by a Health Professional. Please refer to your "Explanation of Benefits, Copayments & Coinsurance" attached hereto for limitations. Other supports for the feet are not covered

## **H. Prosthetic Devices.**

Covered devices must be prosthetics as defined by Medicare. Please refer to your "Explanation of Benefits, Copayments & Coinsurance" attached hereto for limitations.

- (1) Internal Prosthetics. We will provide coverage for internal prosthetics that are surgically emplaced and Medically Necessary for anatomical repair or reconstructive purposes. Internal prosthetic devices are designed to replace all or part of a permanently inoperative, absent or malfunctioning body organ. Examples of internal prosthetic devices include: cardiac pacemakers, implanted cataract lenses and surgically implanted hardware necessary for joint repair or reconstruction.
- (2) External Prosthetics. We will provide coverage for external prosthetics designed to replace all or part of a permanently inoperative, absent or malfunctioning body organ. External prosthetics includes, but are not limited to, artificial limbs or eyes, external breast prostheses, ostomy supplies and initial prescription lenses (eye glasses or contact lenses) following an operation for cataract or other diseases of the eye.
- (3) Hearing Aids. Benefits are provided for hearing aids for children through age 18. Please refer to your "Explanation of Benefits, Copayments & Coinsurance" attached hereto for limitations.

Coverage is provided only for the basic prosthetic and any Medically Necessary special features prescribed by a Health Professional. 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.

## **I. Alternative Benefits.**

In addition to benefits specified in this Certificate, we may provide, outside the terms of this Certificate, benefits for services, for up to a 60-day period, furnished by any Health Professional pursuant to an alternative treatment plan developed by us for a Member whose condition would otherwise require hospitalization.

We may provide such alternative benefits if and only for so long as we determine, among other things, that the alternative services are Medically Necessary, cost-effective and feasible, and that the total benefits paid for such services do not exceed the total Covered Benefits to which you would otherwise be entitled under this Certificate.

If we elect to provide alternative benefits for you in one instance, that shall not obligate us to continue such alternative benefit to you after the first sixty (60) day period has expired or that treatment has ended, nor shall it obligate us to provide the same or similar benefits for any Member in any other instance where an alternative

treatment is not Medically Necessary, cost-effective and feasible. Providing an alternative benefit shall not be construed as a waiver of our right to administer this Certificate thereafter in strict accordance with its expressed terms.

At the expiration of such sixty (60) day period, you may apply in writing for a continuation of the alternative benefits and services being provided outside the terms of this Certificate. Upon such application for renewal, we will review your condition and may agree to a renewal of such alternative benefits and services. Renewals must be in writing and our determination will be final.

The alternative benefits you receive will be in lieu of the Covered Benefits we would normally provide to you under this Certificate for the treatment of your condition. As a result, we may require you to agree to waive certain contractual benefits in order to receive the alternative benefits agreed upon. You may return to utilization of Covered Benefits at any time upon prior written notice to us. However, the Covered Benefits remaining available to you will be reduced in a manner that appropriately reflects the alternative benefits you used.

## **Section E: Exclusions and Pre-existing Condition**

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

1. Contract Exclusions. Except as described under Section D: Services and Benefits, the following services are not Covered Benefits:

**A. Act of War.**

We will not provide coverage for any illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared), participation in a riot or insurrection, or service in the Armed Forces or units auxiliary thereto.

**B. Blood products.**

We will not provide coverage for the cost of blood, blood plasma, other blood products, or blood processing when they are available in a voluntary blood replacement program available to you in your local area, except for blood required for the treatment of hemophilia. We will not cover any charges relating to the cost of donating or storing blood.

**C. Contraceptive Drugs and Devices.**

We will not provide coverage for any service or care related to contraceptive drugs or devices, including, but not limited to, implantable drugs, intra-uterine devices, and diaphragms.

**D. Court Ordered Services.**

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

- (1) The service or care would be covered under this Certificate in the absence of a court order;
- (2) Our procedures have been followed to authorize the service or care; and
- (3) The Medical Director determines, in advance, that the service or care is Medically Necessary and covered under the terms of this Certificate.

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

**E. Criminal Behavior.**

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

**F. Custodial Care.**

We will not provide coverage for any service or care that is custodial in. Care is considered custodial when it is primarily for the purpose of meeting personal needs and includes activities of daily living such as help in transferring, bathing, dressing, eating, toileting and such other related activities.

**G. Dental Care.**

We will not provide coverage for any service or care (including anesthesia and inpatient stays) for treatment of the teeth, gums, or structures supporting the teeth, or for any form of dental surgery not otherwise covered under the "Services and Benefits" section of this Certificate, sub-section "Additional Benefits", paragraph "Dental Care "and/or "Prosthetics" , regardless of the reason that the service or care is necessary. For example, we will not provide coverage for x-rays, fillings, extractions, braces, prosthetics, correction of impactions, treatments for gum disease, therapy or other treatments related to dental TMJ disorder or dental oral surgery unless covered under the above-referenced sections of this Certificate.

**H. Developmental Delay.**

We will not provide coverage for any service or care related to the educational treatment of behavioral disorders and services for remedial education, including evaluation or treatment of learning disabilities, minimal brain dysfunction, development and learning disorders, behavioral training, and cognitive rehabilitation. This exclusion applies to services, treatment, or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language, to instruct a Member whose ability to speak has been lost or impaired to function without that ability, is not covered. 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).

**I. Extraterritorial Coverage.**

We will not provide coverage of any Covered Benefits when the Member is outside of the United States, its possessions or the countries of Canada and Mexico, except for treatment of Emergency Conditions as set forth in this Certificate.

**J. Free Care.**

We will not provide coverage for any service or care that is furnished to you without charge, or that would have been furnished to you without charge if you were not covered under this Certificate. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by a family member, including your spouse, brother, sister, mother, father, son or daughter, or the spouse of any of them, we will presume that the service or care would have been furnished without charge and will not be covered.

**K. Government Hospitals.**

Except as otherwise required by law, we will not provide coverage for any service or care you receive in an Hospital or institution which is owned, operated or maintained by the Veterans Administration (VA), or by a federal, state, or local government, unless the Hospital is an In-Network Provider. However, we will provide coverage for service or care in such a Hospital to treat an Emergency Condition. In such case, we will provide coverage only for as long as emergency care is necessary and it is not possible for you to be transferred to another Hospital.

**L. Government Programs.**

We will not provide coverage for any service or care for which benefits are payable under Medicare or any other federal, state, or local government program, except when required by state or federal law. When you are eligible for Medicare, we will reduce our benefits by the amount Medicare would have paid for the services. Except as otherwise required by law, this reduction is made even if you fail to enroll in Medicare, you do not pay the charges for Medicare, or you receive services at a Hospital that cannot bill Medicare.

However, this exclusion will not apply to you if one of the following applies:

1. **Eligibility for Medicare By Reason of Age.** You are entitled to benefits under Medicare by reason of your age, and the following conditions are met:
  - k. The Subscriber is in “current employment status” (working actively and not retired) with the group contract holder; and
  - l. The Subscriber’s employer maintains or participates in an employer group health plan that is required by law to have this Certificate pay its benefits before Medicare.
2. **Eligibility for Medicare By Reason of Disability Other than End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of disability (other than end-stage renal disease), and the following conditions are met:
  - m. The Subscriber is in “current employment status” (working actively and not retired) with the group contract holder; and
  - n. The Subscriber’s employer maintains or participates in a large group health plan, as defined by law, that is required by law to have this Certificate pay its benefits before Medicare pays.
3. **Eligibility for Medicare By Reason of End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. We will not reduce this Certificate's benefits, and we will provide benefits before Medicare pays, during the waiting period. We will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before we provide benefits under this Certificate.

**M. Hypnosis/Biofeedback.**

We will not provide coverage for hypnosis or biofeedback.

**N. Medical supplies.**

We will not provide coverage for any service or care related to:

- (1) Medical supplies (for example, dressings, and elastic stockings);
- (2) Disposable supplies (for example, diapers, chux, sponges, syringes, incontinence pads, reagent strips, and bandages prescribed for one-time use outside of a provider site); except that this exclusion does not apply to diabetic supplies covered under this Certificate;
- (3) Wigs, hair prosthetics, or hair implants;
- (4) Orthotics not otherwise covered under the “Services and Benefits” section, sub-section “Additional Benefits”, paragraph “Orthotics”; and
- (5) The purchase or rental of household fixtures, including, but not limited to, elevators, escalators, ramps, seat lift chairs, stair glides, saunas, Jacuzzis, whirlpool baths, swimming pools, home tracking systems, exercise cycles, air or water purifiers, hypo-allergenic pillows, mattresses or waterbeds, massage equipment, central or unit air conditioners, humidifiers, dehumidifiers, emergency alert equipment, handrails, heat appliances, improvements made to a house or place of business, and adjustments made to vehicles.

**O. Military Service-Connected Conditions.**

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

**P. No-Fault Automobile Insurance.**

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

**Q. Non-Covered Service.**

We will not provide coverage for any service or care that is not specifically described in this Certificate as a Covered Benefit, or that is related to service or care not covered under this Certificate, even when a Health Professional considers the service or care to be Medically Necessary and appropriate.

**R. Nutritional Therapy.**

We will not provide coverage for any service or care related to nutritional therapy, unless we determine that it is Medically Necessary or that it qualifies as diabetes self management education. We will not provide coverage for commercial weight loss programs or other programs with dietary supplements unless they meet the

requirements of covered medical treatment for obesity listed in paragraph “Medical Treatment of Obesity” found in sub-section “Additional Benefits” in the “Services and Benefits” section of this Certificate.

**S. Prohibited Referral.**

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

**T. Reproductive Procedures.**

We will not provide coverage for any service or care related to the diagnosis or treatment of infertility in connection with in vitro fertilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); cloning, sex change procedures, the reversal of elective sterilizations or any 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.,

**U. Rest Cures.**

We will not provide coverage for any services related to or offered by a spa, mineral water or thermal springs facility, or other such services.

**V. Reversal of Elective sterilization.**

We will not provide coverage for any service or care related to the reversal of elective sterilization.

**W. Routine Care of the Feet.**

We will not provide coverage for services related to routine care of the feet, including treatment for corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.

**X. Self-Help Diagnosis, Training, and Treatment.**

We will not provide coverage for any service or care related to self-help or self-care diagnosis, training, and treatment for recreational, educational, and vocational or employment purposes.

**Y. Services covered under hospice care.**

If you have been formally admitted to a hospice program and we are providing coverage for your hospice care under this Certificate, we will not provide additional coverage under this Certificate for any services related to your terminal illness that have been or should be included in our payment to the hospice program for the care you receive. However, should you require services covered under this Certificate for a condition not covered under the hospice program, coverage will be available under this Certificate for those covered services.

**Z. Services Starting Before Coverage Begins.**

If you are receiving care on the day your coverage under this Certificate begins, we will not provide coverage for any service or care you receive:

- (1) Prior to the first day of your coverage under this Certificate; or

(2) On or after the first day of your coverage under this Certificate, if that service or care is covered under any other health benefits contract, program, or plan. You must notify us, within 48 hours after your coverage begins, that you are receiving care.

**AA. Service that are not a Covered Benefit.**

Any service, care, supply or equipment which is not a Covered Benefit, or any service provided in conjunction with services or items that are not Covered Benefits under this Certificate.

**BB. Smoking Cessation Programs.**

We will not provide coverage for smoking cessation programs.

**CC. Special Charges.**

We will not provide coverage for charges billed to you for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, or completion of claims forms. This exclusion applies to any late charges or extra day charges that you incur upon discharge from a Hospital, because you did not leave a Hospital until after the Hospital's discharge time.

**DD. Social Counseling and Therapy.**

We will not provide coverage for any service or care related to family, marital, religious, sex, or other social counseling or therapy, except as otherwise provided under this Certificate.

**EE. Transportation.**

We will not cover the cost of your transportation incurred by you in order to travel to or from a Facility or Health Professional's office to obtain services, such as a taxi, bus, subway or other private or public transport, except as expressly described in this Certificate.

**FF. Unlicensed Provider.**

We will not provide coverage for any service or care that is provided or prescribed by an unlicensed Health Professional or that is outside the scope of licensure of the duly-licensed Health Professional rendering the service or care.

**GG. Vision and Hearing Examinations, Therapies or Supplies.**

We will not provide coverage for any service or care related to:

- (1) Hearing examinations for the purpose of prescribing, fitting, servicing, or changing hearing aids;
- (2) Eyeglasses, lenses, frames and contact lenses, except for the initial prescription lenses and frames or contact lenses after cataract surgery and other diseases of the eye;
- (3) Vision or hearing therapy, vision training, or orthoptics

**HH. Workers' Compensation.**

We will not provide benefits to the extent that they were provided under Workers' Compensation Law.

**2. Medical Necessity Exclusions.** The following services are not Covered Benefits because they do not meet the definition of Medically Necessary Care:

**A. Certification Examinations.**

We will not provide coverage for any service or care related to a physical examination and/or testing to certify health status, including, but not limited to an examination required for school, employment, insurance, marriage, licensing, travel, camp, sport, or adoption unless otherwise Medically Necessary.

**B. Cosmetic Services.**

We will not provide coverage for any services in connection with elective cosmetic surgery, which is primarily intended to improve your appearance and is not Medically Necessary.

**C. Eye Surgery**

We will not provide coverage for eye surgery to correct refractive error.

**D. Experimental and Investigational Services.**

Unless otherwise required by law, we will not provide coverage for any service or care that consists of a treatment, procedure, drug, biological product, or medical device (collectively, "Service"), or any inpatient stay in connection with a Service, or treatment of a complication related to a Service, which is experimental or investigational. The final determination of whether a service or item is considered experimental or investigational is ours alone based upon a review of the appropriate medical authority. "Experimental or investigational" means that we consider whether:

- (4) The Service is of proven benefit for a particular diagnosis or for treatment of a particular condition;
- (5) The Service is generally recognized by the medical community, as reflected in published, peer-reviewed, medical literature, as effective or appropriate for a particular diagnosis or for treatment of a particular condition; or
- (6) The Service is of proven safety for a person with a particular diagnosis or a particular condition, i.e., is currently being evaluated in research studies to ascertain the safety and effectiveness of the treatment on the well being of a person with the particular diagnosis or in the particular condition;
- (7) The Service is government approved. We will consider governmental approval of a Service considered in determining whether a Service is experimental or investigational, but the fact that a Service has received governmental approval does not necessarily mean that it is of proven benefit, or appropriate or effective treatment for a particular diagnosis or for a particular condition;
- (8) The Service is FDA Approved. The medical device, drug, or biological product must have received final approval of the United States Food and Drug Administration (FDA) to market for the particular diagnosis or for your particular condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once final FDA approval has been granted for a particular diagnosis or for your particular condition, use of the Service (medical device, drug, or biological product) for another diagnosis or condition may require that any or all of the five criteria be met;
- (9) The Service is as beneficial as any established alternatives;

- (10) Improvement must be attainable outside the experimental or investigational setting;
- (11) Published, peer-reviewed, medical literature provides conclusive evidence that the Service has a definite, positive effect on health outcomes. The evidence must include reports of well-designed investigations that have been reproduced by nonaffiliated, authoritative sources with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.
- (12) Published, peer-reviewed, medical literature provides demonstrated evidence that, over time, the Service leads to improvement in health outcomes, i.e., the beneficial effects of the Service outweigh any harmful effects.
- (13) Published, peer-reviewed, medical literature provides proof that the Service is at least as effective in improving health outcomes as established services or technology, or is usable in appropriate clinical contexts in which an established service or technology is not employable.
- (14) Published, peer-reviewed, medical literature provides proof that improvement in health outcomes is possible in standard conditions of medical practice, outside of clinical investigatory settings.

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

See Section F for your right to an external appeal of our determination that a Service is experimental or investigational. We will cover an experimental or investigational service or item ordered and 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.

**E. Immunizations.**

We will not provide immunizations when required for employment, insurance, licensing, marriage, camp, sport, school of any kind, or travel, that are not otherwise Medically Necessary.

**F. Personal Comfort Services.**

We will not provide coverage for any service or care that is for personal comfort or for uses not primarily medical in nature, including, but not limited to: radio, telephone, television, air conditioner, humidifier, dehumidifier, air purifiers; beauty and barber services; exercise equipment, arch supports, foot orthotics, or orthotics used solely for sports.

**G. Transsexual Surgery and Related Services.**

We will not provide coverage for any service or care related or leading up to transsexual surgery, including, but not limited to, hospitalizations; hormone therapies; procedures, treatments, or related services designed to alter the physical characteristics of your biologically determined gender to those of another gender including studies related to sex transformation, even if you have been diagnosed as having gender role or psychosexual orientation problems, unless medically necessary.

### **3. Pre-Existing Conditions.**

- A. A pre-existing condition, disease or ailment is a medical condition, disease or ailment which manifests itself in symptoms which, during the six (6) months preceding the Effective Date of this Contract, would cause an ordinary, prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis or treatment was recommended or received or for a pregnancy existing on the coverage Effective Date of this Contract.
- B. The Member will be responsible for paying for all services provided during the first twelve (12) months of coverage for any pre-existing conditions as defined above. This limitation is waived if:
  - (1) You have been covered under this Contract for more than twelve (12) months; or
  - (2) You have been previously covered under a substantially similar health maintenance organization or health insurance plan or policy, or employer-provided health benefit arrangement and/or this Contract for greater than twelve months. The coverage received previous to coverage under this Contract must be continuous to a date not more than sixty (60) days prior to the Effective Date of the new coverage.
  - (3) If you were covered for less than twelve (12) months under a substantially similar plan or policy, we will reduce the pre-existing waiting period by the length of time you were covered.
  - (4) This credit applies when the benefits provided by the previous plans or policies are substantially similar to the policy under which the credit is to be applied. If the benefits are not substantially similar the credit shall apply to the extent of prior coverage. Individual HMO coverage in effect on December 31, 1995, is deemed substantially similar to the coverage under this Contract if this Contract is in effective on or before February 1, 1996, or within thirty (30) days of the discontinuance of your individual HMO policy.
  - (5) You converted to this plan from a PREFERRED CARE plan that did not contain a pre-existing limitation.
  - (6) This rule applies even if you did not seek medical diagnosis, care or treatment for a pre-existing condition prior to the Effective Date of this Contract.

## **Section F: Claims Procedure**

Except for required Copayments, you should not have to make payments to Participating Providers or participating Hospitals. If, however, services are received from non-Participating Providers, we reserve the right to pay either you or the provider.

### **1. Notice of Claim and Proof of Loss.**

- A. Notice of Claim. You must provide written notice of claim to Preferred Care within twenty (20) days after you receive/obtain services under this Contract. Send your notice to: Preferred Care, ATTN: Claims, 259 Monroe Avenue, Rochester, New York 14607. Include your name, address and identification number on your claim.
- B. Claim Forms. After Preferred Care receives your notice of claim, we will provide you with claim forms. If we fail to do so within fifteen (15) days after we receive your notice, you may send us written proof of loss by including the following:
  - (1) Your name, address and identification number; and
  - (2) Copy of itemized statement for health care services. The itemized bill must include the diagnosis, date and place of service, and a description and charge for each service rendered. The bill must clearly indicate the provider's name, address, phone number, and Tax Identification Number.
  - (3) Written proof of payment. If there is no proof of payment, Preferred Care reserves the right to pay the provider or you.
- C. Proof of Loss. If we send you claim forms, you must complete them and send or deliver them to the address set forth in Section F: Claims Procedure, 1,A of this Contract within ninety (90) days after you received Covered Benefits under this Contract. You may request additional claim forms by contacting Member Services at (585) 325-3113 or (800) 950-3224. TTY users call (585) 325-2629 or (800) 662-1220.
- D. Failure to Provide Proof. Reimbursement for Covered Expenses may be denied or reduced if you do not provide Preferred Care proof of loss within ninety (90) days, unless it was not reasonably possible for you to have given proof within that time. Then the proof must be furnished as soon as reasonably possible. Unless you lack legal capacity, you may not submit proof later than one (1) year from the date you received the Covered Benefits.

- 2. Payment of Claims.** All Covered Expenses for Covered Benefits under this Contract shall be paid when Preferred Care receives proof of loss. Covered Expenses will be paid to the provider or Subscriber as Preferred Care deems appropriate. In the case of a covered Dependent, the custodial parent, can ask Preferred Care in writing to pay the provider of the health services directly.

## **Section G: General Provisions**

### **1. No Assignment.**

You cannot assign any benefits or monies due under the Group Contract or this Certificate to any person, corporation or other organization. Any assignment by you will be void. Assignment means the transfer to another person or to an organization of your right to the services provided under this Certificate or your right to collect money from us for those services.

### **2. Notice.**

We will give the Group Contract holder, and the Group Contract holder will give to Members: identification cards; Certificates; Riders; other necessary materials and all notices which we are required to give to you under this Certificate. If you have to give us any notice, it should be mailed to Preferred Care, Attn: Member Services, 259 Monroe Avenue, Rochester, New York 14607 and to the Group.

### **3. Clerical Error**

Clerical error, whether by the Group or Preferred Care, pertaining to the coverage under this Certificate will not invalidate the coverage otherwise validly in force or continue coverage otherwise validly terminated.

### **4. Your Medical Records.**

In order to provide your coverage under this Certificate, it may be necessary for us to obtain your medical records and information from Facilities or Health Professionals who treat you. 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, 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, including any case and disease management programs. Our actions to provide Covered Benefits include processing your claims, reviewing grievances or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you become covered under this Certificate, you automatically give us permission to obtain and use those records for those purposes.

We agree to maintain that information in accordance with state and federal confidentiality requirements. However, you automatically give us permission to share that information with the New York State Department of Health, quality oversight organizations and third parties with which we contract to assist us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements. You can get a full copy of our Notice of Privacy Practices by contacting our Member Services Center.

### **5. Who Receives Payment Under This Certificate.**

Payments under this Certificate for service provided by an In-Network Provider will be made directly by us to the In-Network Provider. If you receive services from an Out-of-Network Provider, we reserve the right to pay either you or the Out-of-Network Provider directly.

## **6. How to File a Claim.**

In- Network Providers will be paid directly by us. However if you receive services from an Out-of-Network Provider, we reserve the right to pay either you or that Provider directly. If you have paid for Covered Benefits, you may be reimbursed if you:

- A.** Provide us with information necessary, including but not limited to, an itemized bill indicating the diagnosis, date and place of service, a description of the service and the charge for each service rendered. The bill must clearly indicate the provider's name, address, phone number, and Tax Identification Number; and
- B.** The request for reimbursement is made within six (6) months of the date of service. Requests should be mailed to: Preferred Care, Attn: Claims, 259 Monroe Avenue, Rochester, New York 14607.

## **7. Time to File Claims.**

Claims for services under this Certificate must be submitted to us for payment within six (6) months from the date on which the services were provided.

## **8. Time To Sue.**

No action at law or in equity may be maintained against us prior to the expiration of sixty (60) days after written submission of a claim has been furnished to us as required in this Certificate. You must start any lawsuit against us under this Certificate within twenty four (24) months from the date you received the service for which you want us to pay.

## **9. 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 a court located in our nine county service area (Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, or Yates counties) , the State of New York. You agree not to start a lawsuit against us in a court anywhere else. You also consent to these courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order you to defend any action we bring against you.

## **10. Choice of Law.**

This Certificate shall be governed by the laws of the State of New York.

## **11. Recovery of Overpayments.**

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

## **12. Right to Offset.**

If we make a claim payment to you or on your behalf in error, or if you owe us any money, you must repay the amount you owe to us. If we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we owe you.

## **13. Continuation of Benefit Limitations.**

Some of the benefits under this Certificate are limited to a specific number of visits per Calendar Year. You will not be entitled to any additional benefits if your contract status

should change during the Calendar Year. For example, if you convert from dependent to Subscriber, all benefits previously utilized during the Calendar Year will be applied toward your new contract status.

#### **14. Subtitles.**

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

#### **15. Who May Change This Certificate.**

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

#### **16. Changes In this Certificate, Riders, Addenda or Premium.**

- A.** We may unilaterally change this Certificate, the "Prior Justification List," the "Explanation of Benefits, Copayments & Coinsurance" and Riders upon the Group's renewal, if we give the Group Contract holder thirty (30) days' prior notice and if the change is approved by the Superintendent of Insurance.
- B.** Changes to the Group Contract that affect your coverage under this Certificate, including but not limited to the elimination of Riders that provide additional benefits, become effective on the effective date of the change.
- C.** Changes to this Certificate including, but not limited to changes to Covered Benefits, the "Prior Justification List," the "Explanation of Benefits, Copayments & Coinsurance" and Riders become effective on the effective date of the change.

#### **17. Relationship between Preferred Care and Health Professionals.**

The relationship between Preferred Care and Health Professionals is that of an independent contractor relationship. Any agreement between us and In-Network Providers may only be terminated by us or the In-Network Providers. Health Professionals are not agents or employees of Preferred Care, nor is Preferred Care or any of its employees, an employee or agent of any Health Professional. 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 Health Professional. This Certificate does not require any Health Professional to accept a Member as a patient. We do not guarantee a Member's admission to any In-Network Provider or any health benefits program.

#### **18. Material Accessibility.**

We will give the Group Contract holder, and the Group Contract holder will give to Members: Identification cards; Certificates; Riders; and other necessary materials.

#### **19. Premium Payment.**

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

- A. Premium payment is due on or before the first day of the billing period for which coverage is provided.
- B. Only when your Premium payment has been received by us are you entitled to health care services under this Certificate.

## **20. Refund.**

We will give you refund of premiums, if due, to the Group Contract holder.

## **21. Notice of Claim Determination.**

We will provide an explanation of benefits to you whenever you use an out-of-network provider, whenever a claim involves a deductible calculation, or whenever a claim is denied in whole or in part and as a result, you incur out of pocket expenses other than any applicable Deductibles, Coinsurance, or Copayments.

## **22. Identification Cards.**

Identification cards are issued by us for identification only. Possession of any identification card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits the Member's premiums must be paid in full at the time that the services are sought to be received. Wrongfully or illegally knowingly permitting another person to use your Identification Card to receive services constitutes fraud and coverage under this Certificate may be terminated by us and civil and/or criminal legal action may be taken against you.

## **23. Right to Develop Guidelines and Administrative Rules.**

We may develop or adopt standards which describe in more detail when we will make or will not make payments under this Certificate. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether emergency care in the outpatient department of a Hospital was necessary; or whether certain services are Skilled Care. Those standards will not be contrary to the descriptions in this Certificate. If you have a question about the standards which apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Certificate.

## **24. Furnishing Information and Audit.**

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

## **25. Enrollment.**

The Group Contract holder further will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages and social security numbers (or other employee identifiable information) of all group Members covered under

this Certificate, and any other information required to confirm their eligibility for coverage. The Group Contract holder will provide us with the enrollment form including your name, address, age, and social security number and to advise us in writing when you are to be added to or subtracted from our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date the Group's contract with us. If the Group Contract holder fails to so advise us, the Group Contract holder will be responsible for the cost of any claims paid by us as a result of such failure.

## **26. Authorization to Review or Obtain Health Care Reports and Records.**

We are entitled to receive from any Health Professional providing services to Members any and all information reasonably necessary to administer this Certificate, subject to all applicable confidentiality requirements as defined in the General Provisions section of this Certificate. By accepting coverage under this Certificate, the Member, for himself or herself, and for all covered Dependents, authorizes each and every Health Professional who renders services to a Member to:

- A.** Disclose all facts pertaining to the care, treatment and physical condition of the Member to us or a medical, dental, or mental health professional that we may engage to assist in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- B.** Render reports pertaining to the care, treatment and physical condition of the Member to us, or a medical, dental, or mental health professional, that we may engage to assist us in reviewing a treatment or claim; and
- C.** Permit copying of the Member's records by us.

## **27. Service Marks.**

Preferred Assurance Company, Inc. is an independent corporation organized under the Insurance Law of New York State.

## **28. Grievance and Appeal.**

A grievance is a written or verbal request for a first level dispute for a denied service or a request for service or a benefit with which they are not satisfied. We have established a grievance procedure under which you may protest decisions made by us regarding your coverage under your Plan. However, any coverage denial based on a determination by us that a service was not Medically Necessary may only be appealed through the Utilization Review appeal procedures described in Paragraph "32" below, rather than under this grievance procedure.

If you have questions or do not agree with a claim or benefit decision, you or your authorized representative has one hundred eighty (180) days to call or write to Member Services. Your questions and concerns will be answered, the claim or benefit decision reviewed, and a second determination rendered within fifteen (15) days of receipt of the request for all pre-service determinations and within thirty (30) days of receipt of the request for all post-service determinations.

If you disagree with our grievance decision, a formal "Request for an Appeal" should be filed no more than sixty (60) business days of the grievance decision. Supporting medical information may be required. A written response regarding our final determination will be provided within fifteen (15) days of receipt of the request for all pre-service determinations

and within thirty (30) days of receipt of the request for all post-service determinations. This will be our final determination.

In cases where you disagree with our final determination, you have the option to direct a further Appeal to one of the following:

State of New York  
Department of Health  
Corning Tower  
Governor Nelson A. Rockefeller Empire State Plaza  
Albany, New York 12237  
(800) 206-8125 [www.health.state.ny.us](http://www.health.state.ny.us)

State of New York Insurance Department  
1 Commerce Plaza  
Albany, New York 12257  
(800) 342-3736 [www.ins.state.ny.us](http://www.ins.state.ny.us)

You have the right to contact the Department of Health at any time throughout the complaint process. If you have any questions about these procedures or if we can be of assistance, please call Member Services at (585) 325-3113 or (800) 950-3224. TTY users call (585) 325-2629 or (800) 252-2452.

## **29. Utilization Review.**

We have developed a process to review your health services to determine whether the services are or were Medically Necessary. This review process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being rendered (pre-service), when the service is being rendered (continuation of services) or after the service is rendered (post-service). Utilization Review activities include:

**A. Prior Justification.** Services described in the "Prior Justification List" attached hereto require our prior approval. When these services are requested by you or your Health Professional, they will be reviewed to determine if the proposed service meets our guidelines. If the service does not meet our guidelines, you and your Health Professional will be notified by telephone and in writing of the reason for the denial of that service. We will provide such notice within one (1) business days of our receipt of your request if the service request is for an urgent service, or three (3) business days from our receipt of your request for all other pre-service requests for service.

If, prior to making an adverse determination, no attempt was made to consult with your Health Professional, the Health Professional may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to the provider within three (3) business days of the reconsideration.

**B. Continuation of Services.** Hospital, and acute rehabilitation facility admissions and Home Care services are reviewed concurrently to determine if the admission or home care treatment plan continues to be Medically Necessary.

If we determine that the admission or home care treatment plan is no longer Medically Necessary, we will not pay for any further days of such care. You will be notified by telephone and in writing within one (1) business day of receipt of your request.

If, prior to making an adverse determination, no attempt was made to consult with your Health Professional, the Health Professional may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to the provider, by telephone and in writing, within one (1) business day of the reconsideration.

**C. Post-Service Review.** All services are subject to retrospective review to determine if they were Medically Necessary. If we determine retrospectively that the service was not Medically Necessary, we will notify you within thirty (30) days of our receipt of your request and you will be liable for any service which we determine was not Medically Necessary.

**D. Appeal Procedures.** If you disagree with any Utilization Review decision, you have the right to appeal the decision. If you feel you cannot appeal on your own behalf, you can designate a representative to do so. You or your designated representative may file a formal appeal by telephone or in writing. You or your authorized representative have one hundred eighty (180) days from the date you receive notice of a denial of services to appeal by telephone or in writing.

**(1) Non-Urgent Appeals.** Your appeal will be reviewed and a determination will be made within thirty (30) days after our receipt of your request. We will provide you (and where appropriate, your provider) written notice within two (2) business days of our determination.

**(2) Urgent Appeals.** In certain circumstances, you may use our expedited appeal process. This process is applicable to situations in which:

- a. You or your provider requests an extension of a stay in a Hospital or other health care Facility covered under this Plan;
- b. You or your provider requests coverage of additional services which are provided as part of an ongoing course of treatment; or
- c. Your provider determines that an immediate appeal is warranted.

You or your authorized representative may file an urgent appeal by telephone. Your appeal will be reviewed and determined within forty eight (48) hours after receipt of your request. We will provide reasonable access to our **clinical peer reviewer** within one (1) business day of receiving notice of the expedited appeal. We will immediately notify you (and your Provider, when necessary) of our decision by telephone and provide written notice of it within twenty-four (24) hours.

If you are not satisfied with the outcome of an urgent appeal, you may appeal further through the non-urgent appeal process described in sub-section "Appeal Procedures" above. You may also appeal a utilization review determination to an external review agent as described in sub-section "External Appeal" below.

Our failure to meet the timeframes set forth above for an initial utilization review determination shall result in an adverse determination subject to appeal. Our failure to meet the timeframes set forth above for an appeal of an adverse determination shall result in the reversal of the adverse determination.

### **30. External Appeal.**

#### **A. External Appeal in General.**

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

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

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

#### **B. Coverage Determinations Subject to External Appeal.**

This paragraph describes the general conditions for external appeal.

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

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

#### **C. Conditions for External Appeals of Determinations of Medical Necessity.**

You may request an external appeal of a final adverse determination of Medical Necessity issued through the first level of the internal appeal process if you meet the conditions of this subparagraph and the general requirements of paragraph “Coverage Determinations Subject to External Appeal” above. The provisions of this paragraph apply only to external appeal of Medical Necessity determinations.

To request external appeal under this paragraph, the final adverse determination must indicate that the requested service is not Medically Necessary.

The paragraph “Requesting an External Appeal” below provides information on requesting an external appeal.

#### **D. Conditions for External Appeals of Determinations Involving Experimental or Investigational Treatment.**

This paragraph governs external appeals of determinations involving experimental or investigational treatment. This paragraph does not govern determinations involving services provided in clinical trials that are governed by paragraph “External Appeals of Determinations Involving Clinical Trials” below.

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

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

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

If you meet the requirements of this paragraph and all of the requirements of paragraph “Coverage Determinations Subject to External Appeal” above, you may request an external appeal. Paragraph “Requesting an External Appeal” provides information on requesting an external appeal.

#### **E. External Appeals of Determinations Involving Clinical Trials.**

This paragraph governs external appeals of determinations involving services provided in clinical trials.

In order to request an external appeal under this paragraph, your attending Health Professional must certify that you have a life-threatening or disabling condition or disease as described in paragraph “Conditions for External Appeals of Determinations Involving Experimental or Investigational Treatment” above. In addition, your attending Health Professional must certify that a clinical trial for your condition exists and that you are eligible to participate in the clinical trial.

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

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

- (1) The National Institutes of Health (NIH), an NIH cooperative group or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs;
- (2) An entity that has been identified by the NIH as a qualified non-governmental research entity; or
- (3) An Institutional Review Board of a facility that has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

If you meet the requirements of this subparagraph and all of the requirements of paragraph "Coverage Determinations Subject to External Appeal", you may request an external appeal. Paragraph "Requesting an External Appeal" below, provides information on requesting an external appeal.

#### **F. Effect of the External Appeal Agent's Decision.**

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

- (1) For services denied as not Medically Necessary, we will treat the services as Medically Necessary and provide coverage subject to all other conditions of this Certificate.
- (2) For services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of this Certificate.
- (3) For services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of this Certificate. We are not required to pay for drugs or devices that are the subject of the clinical trial.

We will not provide coverage for any service that is not a covered service under this Certificate. In addition, this section does not alter any Coinsurance, Copayment or Deductible responsibilities as otherwise provided for in this Certificate.

#### **G. Requesting an External Appeal.**

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

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

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

You may be charged a fee of \$50 (payable to Preferred Care) to request an external appeal. If this fee would pose a financial hardship to you, you may apply to Preferred Care for a fee waiver. The fee is returned if your external appeal is successful.

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

## **Section H: Termination of Coverage**

Described below are the reasons why your coverage under this Contract may terminate. All terminations are effective on the date specified. When your coverage terminates, you are no longer entitled to any Covered Benefits.

### **1. Termination of the Contract.**

This Contract is effective for one year and will automatically be renewed each year unless it is terminated as set forth below:

- A. You terminate the Contract pursuant to its terms.
- B. We do not receive Premium payment from you as of the date the Premium was due. In this case, your coverage will end on the date to which the Premium has been paid.
- C. You have committed fraud or made an intentional misrepresentation of material fact under the terms of the Contract. In this case, your coverage will terminate thirty (30) days from the date we provide notice to you.
- D. If we terminate the entire class of contracts to which this Contract belongs. In this case, your coverage will terminate ninety (90) days from the date we provide notice to you; or
- E. If we withdraw from the applicable market through which you obtained coverage under this Contract, and we cease offering any products in that market. In this case, your coverage will terminate six (6) months from the date we provide notice to you.

### **2. Termination of Your Coverage under this Contract.**

Described below are the reasons why your coverage under this Contract may terminate. All terminations are effective on the date specified. When your coverage terminates, you are no longer entitled to any Covered benefits.

- A. You Choose to Terminate Your Coverage. You must give Preferred Care thirty (30) days written notice. Your coverage will terminate on the date to which your Premium is paid.
- B. You Committed Fraud in Applying for Coverage or in Filing a Claim Under This Contract. Your coverage will terminate thirty (30) days from the date we provide notice to you.
  - (1) Fraud includes but is not limited to the following:
    - a. Submitting a false claim for benefit; or
    - b. Submitting false information when 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 time frames laid out in Section B: Eligibility, Enrollment and Effective Date of Coverage, of this Contract; 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, and may pursue civil and/or criminal action against you.

- C. The Superintendent of Insurance has Approved the Reason for Termination of Your Coverage. Your coverage will terminate thirty (30) days from the date we provide notice to you. A copy of the reason for the termination of your coverage will be provided to you upon request.
- D. Any reason approved by the Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act. Your coverage will terminate thirty (30) days from the date we provide notice to you.
- E. You or the Covered Dependent has Died. Your coverage under this Contract will terminate on the date of your death or the death of your covered Dependent. If the death of the subscriber or a covered Dependent occurs during a period for which the Premium has been paid, Preferred Care shall refund the Premium or the portion of the Premium actually paid by the subscriber for that person for any period beyond the end of the policy month in which the death occurred.
- F. Termination of the 's Marriage. If you become divorced, or the your marriage is annulled, coverage of your spouse under this Contract will terminate on the date of the divorce or annulment.
- G. A Child becomes Ineligible for Dependent Coverage. Coverage of your child under this Contract will terminate on the date the child no longer qualifies as a Dependent under this Contract.

### **3. 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 your coverage shall be suspended unless you elect, to contact Preferred Care in writing, within sixty (60) days of being ordered to active duty, to continue coverage under this Contract for yourself and eligible Dependents. Continued coverage shall not be subject to evidence of insurability. You must pay the required Premium in advance to Preferred Care, 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, 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 Contract. 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:

- A. 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
- B. A waiting period imposed that had not been completed prior to the period of suspension See Section E: Exclusions, Paragraph 3, Pre-Existing Conditions. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed eleven months.

If other than individual coverage applies and 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 Contract, and to each child individually, upon attaining the limiting age of coverage under this Contract.

## **Section I: Benefits for Total Disability After Termination**

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

1. When You May Continue Benefits. When you are totally disabled, you may continue benefits for Covered Benefits to treat the total disability, if one of the following applies.
  - A. Termination of Employment, Eligibility, or Contract. When your coverage ends, we will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within thirty-one (31) days from the date your coverage ends. The Hospital stay and/or surgery must be for treatment of the injury, sickness, or pregnancy causing the total disability.
  - B. Termination of Active Employment. When your coverage ends, we will provide benefits during a period of total disability for up to twelve (12) months from the date your coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability.
  - C. When Continued Benefits End. The continued benefits will terminate when:
    - (1) You have used all the benefits available;
    - (2) We determine that you are no longer totally disabled; or
    - (3) Benefits are continued under Subparagraph 1, B, above and you reach the end of the twelve-month period from the date your coverage under this Contract ends.

We will never pay more than we would have paid, had you remained covered under this Contract.

## **Section J: Right to New Contract After Termination**

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

### **1. On The Death of the Subscriber.**

If your coverage under this Contract terminates under the Section H: Termination of Coverage, of this Contract because of the death of the Subscriber, you are entitled to purchase a new contract as a direct payment member.

### **2. Termination of Your Marriage.**

If your coverage under this Contract terminates under the Section H: Termination of Coverage of this Contract because you become divorced from the Subscriber or your marriage is annulled, you are entitled to purchase a new contract as a direct payment member.

### **3. Termination of Coverage of a Child.**

If your coverage under this Contract terminates under the Section H: Termination of Coverage of this Contract because you no longer qualify as a child, you are entitled to purchase a new contract as a direct payment member.

### **4. Termination of Your Temporary Continuation of Coverage.**

If your coverage under this Contract terminates under the Section H: Termination of Coverage of this Contract because you are no longer eligible for continuation of coverage, you are entitled to purchase a new contract as a direct payment member.

### **5. When to Apply for the New Contract.**

If you are entitled to purchase a new contract, as described above, you must apply to us for the new contract within thirty (30) days after termination of your coverage under this Contract. You must also pay the first Premium of the new contract within this same 30-day period. However, notwithstanding the above, if we determine that you do not reside in New York State, you will not be entitled to purchase a new contract as a direct payment Subscriber if:

- A. We determine that similar coverage is available through a local health insurance plan operating in the area in which you are located; and
- B. The time you were covered under this Contract will count towards any applicable waiting periods under the available coverage.

### **6. 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 direct payment products.

## **Section K: Coordination of Benefits, Third Party Payments and Double Coverage**

This Section applies if you have other group health benefits coverage with another Plan or if another party may be held responsible for the services which were provided as a Covered Benefit to you.

- 1. When You Have Other Health Benefits.** It is not unusual to find yourself covered by two health insurance contracts, plans or policies ("Plans") providing similar benefits both issued through or to groups. When that is the case and you receive an item of service that would be covered by both Plans, we will coordinate benefit payments with any payment made under the other Plan. One Plan will pay its full benefit as the primary plan. The other Plan will pay secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be Plans:
  - A. Any group or blanket insurance contract, plan or policy, including HMO and other prepaid group coverage, except that blanket school accident coverage or blanket coverage offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a Plan;
  - B. Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;
  - C. Local health insurance plan or other service type group plan;
  - D. Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid or any other plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered a Plan; and
  - E. Medical benefits coverage in group or individual mandatory automobile "no-fault" or traditional "fault" type contracts.
- 2. Rules to Determine Payment.** To determine which plan is primary, the following rules have been established. Applying them in order, the first which applies to your situation shall determine which Plan is primary:
  - A. If the other plan does not have a provision similar to this one, then it will be primary;
  - B. If you are covered under one plan as an employee, Subscriber or Member and you are only covered as a Dependent under the other plan, the plan which covers you as an employee, Subscriber or Member will be primary.
  - C. Subject to the provisions regarding separated or divorced parents below, if you are covered as a child under both plans, the plan of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the plan which covered the parent longer is primary. If the other plan does not have the rule described immediately above, but instead has a rule based on gender of a parent and, as a result, the plans do not agree on which shall be primary, then the father's plan will be primary.

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

- (1) if the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary
  - (2) if no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:
    - a. first, the plan of the parent with custody of the child;
    - b. then, the plan of the spouse of the parent with custody of the child;
    - c. finally, the plan of the parent not having custody of the child.
- D. If you are covered under one of the plans as an active employee (neither laid-off nor retired nor as the Dependent of such an active employee), and you are covered as a laid-off or retired employee or a laid-off or retired employee's Dependent under the other plan, the plan covering you as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.
- E. If none of the above rules determine which plan shall be primary, then the plan which has covered you for the longest time will be primary.
- F. None of the above rules as to coordination of benefits will serve as a barrier to you receiving Covered Benefits under this Contract.
- G. We will not pay for Hospital care if you are a patient in a Hospital on the date your coverage under this Contract becomes effective, to the extent coverage is provided under any other Plan.
- 3. Payment of the Benefit When This Plan is Secondary.** When this plan is secondary, your Covered Benefits will be reduced so that the total benefits payable under the other plan and this plan do not exceed your expenses for an item of service. However, we will not pay more than we would have paid if we were primary.
- We count as actually paid by the primary plan any items of expense that would have been paid if you had made the proper and timely claim. If the primary plan claims is "excess only" or "always secondary", we will request information from that plan so we can process your claims. If the primary plan does not respond within 30 days, we will assume its benefits are the same as ours. If the primary plan sends the information after 30 days, we will adjust our payment, if necessary.
- 4. Right to Receive and Release Necessary Information.** We have the right to release or obtain information which we believe necessary to carry out the purpose of this section. We need not tell you or obtain anyone's consent or authorization to do this except as required by Article 25 of the New York General Business Law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information which we request. If you do not furnish the information to us, we have the right to deny payments.

5. **Payments to Others.** We may repay to any other person, insurance company or organization the amount which it paid for your Covered Benefits and which we decide we should have paid. These payments are the same as benefits paid.
6. **Subrogation and Duty to Cooperate with Us.** 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 Covered Benefits as a result of that injury or illness, we will be subrogated and succeed to the right of recovery against the party responsible for your illness or injury to the extent of the Covered Benefits we have paid.

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 and other penalties which apply under certain circumstances are noted below. Those circumstances are:

- A. 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;
- B. 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 instituted on our initiative.

The penalty for failing to cooperate under this Subparagraph is that you will be responsible to repay to us the amount of the benefits we have paid. We agree to invoke this Subparagraph only when your illness or injury caused by a third party results in our expenditure on your behalf of an amount exceeding \$500 under this Coverage. In any of these provisions where we must give our prior written consent, we agree not to unreasonably withhold our prior consent and we agree to waive all penalties under these provisions if we do not give or withhold our prior consent within thirty (30) days from the date you or your legal representative seeks prior consent in writing from us.

7. **Our right to Collect Over payment.** In some cases we may have inadvertently made a payment even though you have coverage under another plan. Under these circumstances, you must refund to us the amount by which we should have reduced our payment. We also have the right to recover the overpayment from the other plan if we have not already received payment from that other plan. You must sign any document which we deem necessary to help us recover any overpayment.