HEALTH REPUBLIC
INSURANCE

This is Your

EXCLUSIVE PROVIDER ORGANIZATION CONTRACT

Issued by

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

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

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

This Contract offers You the option to receive Covered Services on two benefit levels:

In-Network Preferred Benefits. In-network preferred benefits are the highest level of coverage available. In-network preferred benefits apply when Your care is provided by Preferred Providers in Our MagnaCare[sm] Choice Network. You should always consider receiving health services first through Our preferred MagnaCare[sm] Choice Network.

In-Network Benefits. In-network benefits are the intermediate level of coverage available. In-network benefits apply when Your care is provided by Participating Providers that are not Preferred Providers and are in Our MagnaCare[sm] Extra Network. You should always consider receiving health care services first through Preferred Providers and then from Participating Providers that are not Preferred Providers.

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

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

Signed By: Debra Friedman

Debra Friedman
Chief Executive Officer

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SECTION I. DEFINITIONS

Defined terms will appear capitalized throughout the Contract.

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

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

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

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

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

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

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

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

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

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

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

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

Dependents: The Subscriber's Spouse and Children.

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

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

- is appropriate for use in the home.

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

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

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

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

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

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

Facility: A Hospital; ambulatory surgery Facility; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; home health agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to article 27-J of the public health law; an institutional Provider of mental health or chemical dependence and abuse treatment operating under Article 31 of the New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or other Provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable). If You receive treatment for chemical dependence or abuse outside of New York State, the Facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") to provide a chemical abuse treatment program.

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

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

Health Care Professional: An appropriately licensed, registered, or certified Physician; osteopath; dentist; optometrist; chiropractor; psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist certified to

administer immunizing agents; or any other licensed, registered, or certified Health Care Professional under Title 8 of the Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Contract.

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

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

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

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

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

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

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

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

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

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

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

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

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website http://newyork.healthrepublic.us/network or upon Your request to Us. The list will be revised from time to time by Us. You will pay higher Cost-Sharing to see a Participating Provider as compared to a Preferred Provider, but less than if You received Covered Services from a Non-Participating Provider.

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

Plan Year: A 12-month calendar year.

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

Preferred Provider: A Provider who has a contract with Us to provide services to You at the highest level of coverage available to You. You will pay the least amount of Cost-Sharing to see a Preferred Provider.

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

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

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

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

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

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

Service Area: The geographical area, designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of the following counties for the MagnaCare[sm] Extra Network: Albany, Bronx, Brooklyn, Chautauqua, Columbia, Delaware, Dutchess, Erie, Essex, Greene, Hamilton, Monroe, Nassau, New York, Niagara, Onandaga, Ontario, Orange, Orleans, Putnam, Queens,

Rensselaer, Rockland, Saratoga, Schenectady, Staten Island, Suffolk, Sullivan, Ulster, Warren, Washington, and Westchester. Our Service Area consists of the following counties for the MagnaCare[sm] Choice Network: Bronx, Essex, Hamilton, Nassau, New York, and Westchester.

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

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

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

Subscriber: The person to whom this Contract is issued.

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

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

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

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

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

You, Your: The Member.

SECTION II. HOW YOUR COVERAGE WORKS

2.1 Your Coverage under this Contract

You have purchased a Freelancers Health Service Corporation DBA Health Republic Insurance of New York Contract from Us. We will provide the benefits described in this Contract to You and Your Covered Dependents. You should keep this Contract with Your other important papers so that it is available for Your future reference.

2.2 Covered Services

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

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

2.3 Participating Providers

To find out if a Provider is a Participating Provider:

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

2.4 Preferred Providers

Some Participating Providers are also Preferred Providers. Certain services must be obtained from Preferred Providers. See the Schedule of Benefits in Section XIII of this Contract for coverage of Preferred Provider services.

2.5 The Role of Primary Care Physicians

This Contract does not have a gatekeeper, usually known as a Primary Care Physician (PCP). You do not need a written Referral from a PCP before receiving Specialist care from a Participating Provider. However, the role of a PCP is to coordinate the majority of a members care. You visit any Participating PCP who is available from the list of PCPs in the EPO MagnaCare[sm] Extra Network and MagnaCare[sm] Choice Network and You will be billed zero copayment for any office visit. For purposes of Cost-Sharing, if You seek services from a Primary Care Physician (or a Physician covering for a Primary Care Physician) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits in section XIII of this Contract. However, You may need to request Preauthorization before You receive certain services. See the Schedule of Benefits in Section XIII of this Contract for the services that require Preauthorization.

2.6 Services Subject To Preauthorization

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

2.7 Preauthorization/Notification Procedure

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

You must contact Us to request Preauthorization as follows:

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

You must contact Us to provide notification as follows:

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

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

2.8 Failure to Seek Preauthorization or Provide Notification

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

2.9 Medical Management

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

2.10 Care Must Be Medically Necessary

We Cover benefits described in this Contract as long as the health care service, procedure, treatment, test, device, Prescription Drug, or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of: Your medical records; Our medical policies and clinical guidelines; medical opinions of a professional society, peer review committee or other groups of Physicians; reports in peer-reviewed medical literature; reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data; professional standards of

safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment; the opinion of Health Care Professionals in the generally recognized health specialty involved; and the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

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

2.11 Important Telephone Numbers and Addresses

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

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

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

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

OUR WEBSITE
http://newyork.healthrepublic.us

SECTION III. ACCESS TO CARE AND TRANSITIONAL CARE

3.1 Referral to a Non-Participating Provider

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

3.2 When Your Provider Leaves the Network

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

In order for You to continue to receive Covered services for up to 90 days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-Network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients, or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

3.3 New Members In a Course of Treatment

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

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

SECTION IV. COST-SHARING EXPENSES AND ALLOWED AMOUNT

For further details, refer to the Schedule of Benefits in Section XIII.

4.1 Deductible

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

4.2 Copayments

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

4.3 Coinsurance

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

4.4 Out-of-Pocket Limit

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

4.5 Allowed Amount

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

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

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

SECTION V. WHO IS COVERED

5.1 Who is Covered Under this Contract

You, the Subscriber to whom this Contract is issued, are covered under this Contract. You must live, work, or reside in Our Service Area to be covered under this Contract. If You are eligible for Medicare, You are not eligible to purchase this Contract. If You selected one of the following types of coverage, members of Your family may also be covered.

5.2 Types of Coverage

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

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

5.3 Children Covered Under This Contract

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

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

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

5.4 Open Enrollment

You can enroll under this Contract during an initial open enrollment period that runs from October 1, 2013 through March 31, 2014. If the Exchange receives Your selection between October 1, 2013 and December 15, 2013, Your coverage will begin on January 1, as long as Your applicable premium payment is received by then. If Your selection is received by the Exchange during the first and fifteenth day of the month of January, February, or March of 2014, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received by the Exchange between the sixteenth and last day of the month of December 2013, January, February, or March of 2014, Your coverage will begin on the first day of the second month, as long as Your applicable premium payment is received by then.

You can enroll under this Contract during an annual open enrollment period that runs from October 15 through December 7. If the Exchange receives Your selection between these dates, Your coverage will begin on January 1 of the following year, as long as the applicable premium payment is received by then.

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

5.5 Special Enrollment Periods

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

- You or Your Spouse or Child loses minimum essential coverage.
- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange as evaluated and determined by the Exchange.
- You adequately demonstrate to the Exchange that another qualified health plan in which You were enrolled substantially violated a material provision of its contract.
- You move and become eligible for new qualified health plans.
- You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.
- If You are an Indian, as defined in 25 U.S.C. 450b(d), You may enroll in a qualified health plan or change from one qualified health plan to another one time per month.
- You demonstrate to the Exchange that You meet other exceptional circumstances as the Exchange may provide.
- You were not previously a citizen, national, or lawfully present individual and You gain such status.
- You are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions.

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

If You enroll because You lost minimum essential coverage or because You got married, Your coverage will begin on the first day of the month following Your loss of coverage or marriage.

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

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

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

5.6 Domestic Partner Coverage

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

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
   a. The affidavit must be notarized and must contain the following:
      - The partners are both eighteen years of age or older and are mentally competent to consent to contract;
      - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
      - The partners have been living together on a continuous basis prior to the date of the application;
      - Neither individual has been registered as a member of another domestic partnership within the last six months; and
   b. Proof of cohabitation (e.g., a driver's license, tax return, or other sufficient proof); and
   c. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
      - A joint bank account
      - A joint credit card or charge card
      - Joint obligation on a loan
      - Status as an authorized signatory on the partner's bank account, credit card or charge card
      - Joint ownership of holdings or investments
      - Joint ownership of residence
      - Joint ownership of real estate other than residence
      - Listing of both partners as tenants on the lease of the shared residence
      - Shared rental payments of residence (need not be shared 50/50)
      - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
      - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
      - Shared household budget for purposes of receiving government benefits
      - Status of one as representative payee for the other's government benefits
      - Joint ownership of major items of personal property (e.g., appliances, furniture)
      - Joint ownership of a motor vehicle

- Joint responsibility for child care (e.g., school documents, guardianship)
- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)
- Execution of wills naming each other as executor and/or beneficiary
- Designation as beneficiary under the other's life insurance policy
- Designation as beneficiary under the other's retirement benefits account
- Mutual grant of durable power of attorney
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
- Affidavit by creditor or other individual able to testify to partners' financial interdependence
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI. COVERED SERVICES

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

6.1 Preventive Care
We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles, and Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at 888.990.5702 or visit Our website at http://newyork.healthrepublic.us for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

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

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

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

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

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

6.1.3 Adult Immunizations

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

6.1.4 Well-Woman Examinations

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

6.1.5 Mammograms

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

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

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

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

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

6.1.6 Family Planning and Reproductive Health Services

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

We also Cover vasectomies.

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

6.1.7 Bone Mineral Density Measurements or Testing

We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to Section VI of the Contract. Bone mineral density measurements or tests, drugs, or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in

accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
- On a prescribed drug regimen posing a significant risk of osteoporosis; or
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or,
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

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

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

6.1.8 Screening for Prostate Cancer

We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

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

6.2 PRE-HOSPITAL EMERGENCY MEDICAL SERVICES AND AMBULANCE SERVICES

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

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

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

- Placing the health of the person afflicted with such condition or, with
- respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;

- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

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

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

6.2.1 Non-Emergency Ambulance Transportation:

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

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

See the Schedule of Benefits in Section XIII of this Contract for any Preauthorization requirements for non-emergency transportation.

6.2.2 Limitations/Terms of Coverage:

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

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

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

6.3 EMERGENCY SERVICES

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

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

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

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

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

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

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

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

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

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

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

6.3.1 Hospital Emergency Department Visits

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

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

6.3.2 Emergency Hospital Admissions

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

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

6.3.3 Payments Relating to Emergency Services Rendered

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

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

6.4 URGENT CARE

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

A. In-Network

You may obtain Urgent Care from a Participating Physician or a Participating Urgent Care Center.

B. Out-of-Network

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

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

6.5 OUTPATIENT AND PROFESSIONAL SERVICES

(For other than Mental Health and Substance Use)

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

6.5.1 Acupuncture

We cover acupuncture services.

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

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

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

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

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

6.5.7 Dialysis
We Cover dialysis treatments of an acute or chronic kidney ailment.

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

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

6.5.8 Habilitation Services

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

6.5.9 Home Health Care

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

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

6.5.10 Interruption of Pregnancy

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

6.5.11 Infertility Treatment

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

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

i. Cloning.
j. Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.
k. All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

6.5.12 Infusion Therapy

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

6.5.13 Laboratory Procedures, Diagnostic Testing, and Radiology Services

We Cover x-ray, laboratory procedures, and diagnostic testing, services, and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

6.5.14 Maternity and Newborn Care

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

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

6.5.15 Medications for Use in the Office:

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

6.5.16 Office Visits

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

6.5.17 Outpatient Hospital Services

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

6.5.18 Preadmission Testing

We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient facilities prior to a scheduled surgery in the same Hospital provided that: the tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed; reservations

for a Hospital bed and operating room were made prior to the performance of the tests; surgery takes place within seven days of the tests; and the patient is physically present at the Hospital for the tests.

6.5.19 Rehabilitation Services

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

We Cover speech and physical therapy only when:

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

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

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

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

6.5.20 Second Opinions

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

6.5.21 Surgical Services

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the

surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

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

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

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

6.5.22 Oral Surgery

We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

6.5.23 Reconstructive Breast Surgery

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

6.5.24 Other Reconstructive and Corrective Surgery

We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when:

- It is performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect; or
- It is incidental to surgery or follows surgery that was necessitated by trauma, infection, or disease of the involved part; or
- It is otherwise Medically Necessary.

6.5.25 Transplants

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

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

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

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

6.6 ADDITIONAL BENEFITS, EQUIPMENT, AND DEVICES

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

6.6.1 Autism Spectrum Disorder

We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

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

  Repair, replacement fitting, and adjustments of such devices are Covered when made necessary by normal wear and tear or significant change in Your physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not Covered ; however, We will Cover one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to

Your current functional level. We will not provide Coverage for delivery or service charges or for routine maintenance.

- **Behavioral Health Treatment:** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by an applied behavior analysis Provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

  Our Coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.
- **Psychiatric and Psychological Care**: We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.
- **Therapeutic Care:** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Contract.
- **Pharmacy Care**: We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Contract.

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

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

Nothing in this Contract shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services

pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

6.6.2 Diabetic Equipment, Supplies, and Self-Management Education

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

6.6.3 Supplies

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

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

6.6.4 Self-Management Education

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

management education; or when a refresher course is necessary. It must be provided in accordance with the following:

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

6.6.5 Limitations

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

6.6.6 Durable Medical Equipment and Braces

We Cover the rental or purchase of durable medical equipment and braces.

6.6.7 Durable Medical Equipment

Durable Medical Equipment is equipment which is:

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

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

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

6.6.8 Braces

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

6.6.9 Hearing Aids

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

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

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

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

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

6.6.10 Hospice

Hospice Care is available if Your primary attending Physician has certified that You have six months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

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

6.6.11 Medical Supplies

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

6.7 PROSTHETICS

6.7.1 External Prosthetic Devices

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials. Dentures or other devices used in connection with the teeth are not Covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. Eyeglasses and contact lenses are not Covered under this Section of the Contract and are only covered under the pediatric vision benefit in Section VI in this Contract. We do not Cover orthotics.

For adults, We Cover the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown.

Coverage is for standard equipment only. We do not otherwise Cover the cost of repairs or replacement.

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

6.7.2 Internal Prosthetic Devices

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.

6.8 INPATIENT SERVICES

(For other than Mental Health and Substance Use)

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

6.8.1 Hospital Services

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

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

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

6.8.2 Observation Services

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

6.8.3 Inpatient Medical Services

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

6.8.4 Inpatient Stay for Maternity Care

We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Contract and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits that apply to home care benefits.

6.8.5 Inpatient Stay for Mastectomy Care

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

6.8.6 Autologous Blood Banking Services

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

6.8.7 Rehabilitation Services

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

We Cover speech and physical therapy only when:

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

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

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

6.8.8 Skilled Nursing Facility

We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent, or domiciliary care is not Covered (see the “Exclusions and Limitations” Section of this Contract). An admission to a Skilled

Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to 200 days, per Plan Year, for non-custodial care.

6.8.9 End of Life Care

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

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

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

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

3. Or if it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare rates.

6.8.10 Limitations/Terms of Coverage

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

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

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

6.9 MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES

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

6.9.1 MENTAL HEALTH CARE SERVICES

A. Inpatient Services

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

B. Outpatient Services
We Cover outpatient mental health care services, including but not limited to partial Hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous, and emotional disorders. Such Coverage is limited to Facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a Facility operated by the Office of Mental Health; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of NY Ins. Law §§ 3221(l)(4)(D), 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.

C. Limitations/Terms of Coverage

a. We will not Cover benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs.
b. We will not Cover mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the Office of Children and Family Services.
c. We will not Cover services solely because they are ordered by a court.

6.9.2 SUBSTANCE USE SERVICES

A. Inpatient Services
We Cover inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes Coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse, or chemical dependence treatment programs.

B. Outpatient Services
We Cover outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such Coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by Physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV, and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation; and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.

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

6.10 PRESCRIPTION DRUG COVERAGE

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

6.10.1 Covered Outpatient Prescription Drugs

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

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

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria.
- Non-prescription enteral formulas for home use for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the Infertility Section of this Contract.
- Off-Label Cancer drugs, so long as, the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Prescription Drugs for smoking cessation.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

You may request a copy of Our drug formulary. Our drug formulary is also available on Our website at http://newyork.healthrepublic.us/formulary. You may also inquire if a specific drug is Covered under this Contract by contacting us at the number on Your ID card.

6.10.2 Refills

We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order or Designated pharmacy as ordered by an authorized Provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits in Section XIII of this Contract.

6.10.3 Benefit and Payment Information

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

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

   An additional charge may apply when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request, when a chemically equivalent Prescription Drug is available on a lower tier unless We approve coverage at the higher tier. You will have to pay the difference between the cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference must be paid in addition to the lower tier Copayment or Coinsurance.

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

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

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

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required In-Network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at 888.990.5702 or visit our website at http://newyork.healthrepublic.us to request approval.

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

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

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

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

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

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

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

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

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

To maximize Your benefit, ask Your Physician to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order supplier regardless of the number of days supply written on the Prescription Order or Refill.

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

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

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

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

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

Benefits will be provided for drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one Cost-Share amount for a 30-day supply up to a maximum of two and a half Cost-Share amounts for a 90-day supply. We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with Us in which it agrees to be bound by the same terms and conditions as a Participating mail order pharmacy.

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

I. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the Schedule of Benefits in Section XIII of this Contract or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under Section VI of this Contract.

6.10.4. Medical Management

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

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

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

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

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

6.10.5 Limitations/Terms of Coverage

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

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

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

D. Various specific and/or generalized "use management" protocols will be used from time-to-time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

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

K. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under Section VI of this Contract.

L. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs or as otherwise provided in this Contract.

M. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

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

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

P. Your benefit for insulin, diabetic Prescription Drugs, supplies, and equipment is not provided under this Section of the Contract and is Covered under Section VI of the Contract. Your benefit for insulin and diabetic Prescription Drugs, supplies and equipment will be provided under this Section of the Contract if the Cost-Sharing is more favorable to You under this Section of the Contract than the Cost-Sharing under Section XIII of the Contract.

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

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

S. We do not Cover nutritional supplements (formulas), non-prescription enteral formulas, and modified food solid products except as described under the Covered Outpatient Prescription Drug Section.

6.10.6. General Conditions

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

B. **Drug Utilization, Cost Management, and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage. We may, from time-to-time, also enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors, or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Instead, any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities, and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

6.10.7 DEFINITIONS

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

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

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

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

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

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

Participating Pharmacy: A pharmacy that has:

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

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

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

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

Prescription Order or Refill: The directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

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

6.11 WELLNESS BENEFITS

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

Memberships in tennis clubs, country clubs, weight loss clinics, spas, or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited

to actual work-out visits. We will not provide reimbursement for equipment, clothing, vitamins, or other services that may be offered by the facility (massages, yoga, etc.).

In order to be eligible for reimbursement, You must:

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

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

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

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

6.12 PEDIATRIC VISION

Pediatric Vision Care

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

6.12.1 Pediatric Vision Care

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

6.12.2 Vision Examinations

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

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

6.12.3 Prescribed Lenses and Frames

We Cover standard prescription lenses or contact lenses once in any 12 month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames adequate to hold lenses once in any 12 month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation.

SECTION VII. EXCLUSIONS AND LIMITATIONS

No Coverage is available under this Contract for the following:

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

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

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

7.4 Coverage Outside of the United States, Canada or Mexico
We do not Cover care or treatment provided outside of the United States, its possessions, Canada, or Mexico except for Emergency Services to treat Your Emergency Condition.

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

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

7.7 Felony Participation
We do not Cover any illness, treatment, or medical condition due to Your participation in a felony, riot, or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence.

7.8 Foot Care
We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, except as specifically listed in this Contract. For foot care related to diabetes, see Section VI of this Contract.

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

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

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

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

7.13 No-Fault Automobile Insurance
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

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

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

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

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

7.18 Vision Services
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in Section VI of this Contract.

7.19 Workers' Compensation

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

7.20 War

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

SECTION VIII. CLAIM DETERMINATION

8.1 Claims

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

8.2 Notice of Claim

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the Provider making the charge, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on your ID card or visiting Our website at http://newyork.healthrepublic.us. Completed claim forms should be sent to the address in Section II of this Contract or on Your ID card.

8.3 Timeframe for Filing Claims

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

8.4 Claims for Prohibited Referrals

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

8.5 Claim Determinations

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

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

A pre-service claim is a request that a service or treatment be approved before it has been received. A post-service claim is a request for a service or treatment that You have already received.

8.6 Pre-Service Claim Determinations

If We have all the information necessary to make a determination regarding a pre-service claim (for example a Referral or a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

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

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

8.7 Urgent Pre-Service Reviews

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

8.8 Post-Service Claim Determinations

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

SECTION IX. GRIEVANCE, UTILIZATION REVIEW, AND EXTERNAL APPEALS

9.1 GRIEVANCES

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

9.1.1 Filing a Grievance

You can contact Us by phone at 888.990.5702 or in writing to file a Grievance. You must use Our Grievance form for written Grievances. You may submit an oral Grievance in connection with a denial of a referral or a Covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when you received the decision you are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We'll take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

9.1.2 Grievance Determination

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified, or registered health care professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided Within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for service.)	In writing, within 30 calendar days of receipt of Your Grievance.

If You remain dissatisfied with Our Grievance determination or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at
1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

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

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

9.2 UTILIZATION REVIEW

9.2.1 Utilization Review

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card.

All determinations that services are not Medically Necessary will be made by licensed Physicians or by licensed, certified, registered, or credentialed health care professionals who are in the same profession and same or similar specialty as the health care Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not or were not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, You can contact Us or visit our website at http://newyork.healthrepublic.us.

9.2.2 Preauthorization Reviews

If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three business days of receipt of the request.

If We need additional information, We will request it within three business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

9.2.3 Urgent Preauthorization Reviews

With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will follow within one calendar day of the decision. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period.

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

9.2.4 Concurrent Reviews

Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one business day of receipt of all necessary information. If We need additional information, We will request it within one business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one business of Our receipt of the information or, if We do not receive the information, within one business day of the end of the 45-day time period.

9.2.5 Urgent Concurrent Reviews

For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one business day of receipt of the request for coverage if all necessary information was included or three calendar days from the verbal notification if all necessary information was not included. If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, the Urgent Preauthorization Review timeframes apply.

9.2.6 Retrospective Reviews

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

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

9.2.7 Retrospective Review of Preauthorized Services

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

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

9.2.8 Reconsideration

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

9.2.9 Utilization Review Internal Appeals

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

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

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

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

9.2.10 Standard Appeal

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

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

9.2.11 Expedited Appeals

Appeals of reviews of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. Expedited Appeals are not available for retrospective reviews. For expedited Appeals, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited Appeals will be determined within the lesser of 72 hours from receipt of the Appeal or two business days of receipt of the information necessary to conduct the Appeal.

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

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

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

I. YOUR RIGHT TO AN EXTERNAL APPEAL

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

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

- The service, procedure, or treatment must otherwise be a Covered Service under the Contract; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or

- You file an external appeal at the same time as You apply for an expedited internal Appeal; or
- We fail to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

II. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY

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

III. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL

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

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

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

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

IV. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS OUT-OF NETWORK

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

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

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

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

V. THE EXTERNAL APPEAL PROCESS

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

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

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

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

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

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

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

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

VI. YOUR RESPONSIBILITIES

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

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

SECTION X. TERMINATION OF COVERAGE

Coverage under this Contract may be terminated as follows:

1. Coverage under this Contract shall automatically be terminated on the first of the following to apply:
    a. Upon Your death, coverage under this Contract will terminate unless You have coverage for Dependents. If You have coverage for Dependents, this Contract will terminate as of the last day of the month for which the Premium has been paid.
    b. For Spouses in cases of divorce, the date of the divorce.
    c. For Children, until the end of the month in which the Child turns 26 years of age. For all other Dependents, the date in which the Dependent ceases to be eligible.

2. You may terminate coverage under this Contract at any time by giving the Exchange at least 30 days' prior written notice.

3. We may terminate coverage under this Contract on 30 days' written notice as follows:
    a. For non-payment of Premiums. Premiums are to be paid by You to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:
    If You do not receive advance payments of premium tax credits for coverage in the Exchange and fail to pay the required Premium within a 30 day grace period, coverage will terminate retroactively back to the last date Premiums were paid. You will be responsible to pay for any claims submitted during the grace period.
    If You receive advance payments of the premium tax credit and have paid at least one full month's Premium, coverage will terminate one month after the last day Premiums were paid. That is, retroactive termination will not exceed 61 days. We may pend claims incurred during the 61 day grace period. You will be responsible to pay for any claims incurred during the 61 day grace period if Your coverage terminates.
    b. If You have performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on Your enrollment application or in order to obtain coverage for a service, coverage will terminate immediately upon a written notice to You from the Exchange. However, if You make an intentional misrepresentation of material fact in writing on Your enrollment application we will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage and Your application is attached to this Contract. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Contract.
    c. If You no longer live, reside, or work in Our Service Area.
    d. The date on You cease to meet the eligibility requirements for coverage.
    e. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide You with at least 5 months prior written notice.
    f. The date the Contract is terminated because We terminate or cease offering all hospital, surgical and medical expense coverage in the individual market, in this state. We will provide written notice to You at least 180 days prior to when Your coverage will cease.

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

See Section XI of this Contract for Your right to conversion to an individual Contract.

SECTION XI. WHAT HAPPENS IF YOU LOSE COVERAGE

11.1 EXTENSION OF BENEFITS

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

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

11.1.1 When You May Continue Benefits

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

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

11.1.2 Limits on Extended Benefits

We will not pay extended benefits:

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

11.2 CONVERSION RIGHT TO NEW CONTRACT AFTER TERMINATION

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

A. **Termination of Your Marriage.** If a Spouse's coverage terminates under Section X of this Contract because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.
B. **Termination of Coverage of a Child.** If a Child's coverage terminates under Section X of this Contract because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.
C. **On the Death of the Subscriber.** If coverage terminates under Section X of this Contract because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

11.2.1 When to Apply for the New Contract

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

11.2.2 The New Contract

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

11.2.3 When Conversion is Not Available

We will not issue You an individual direct payment Contract if the issuance of the new Contract will result in overinsurance or duplication of benefits according to the standards We have on file with the Superintendent of the New York State Department of Financial Services.

11.2.4 Temporary Suspension Rights for Members of the Armed Forces

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

A. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and

B. You serve no more than five years of active duty.

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

Upon completion of active duty:

Your coverage may be resumed as long as You make written application to Us and remit the premium within 60 days of the termination or active duty. The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XII. GENERAL PROVISIONS

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

2. **Assignment.** You cannot assign any benefits or monies due under this Contract 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 Contract or your right to collect money from us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

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

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

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

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

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

8. **Furnishing Information and Audit.** All persons covered under this Contract will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. You must provide Us with information over the telephone for reasons like the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

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

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

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

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

12. **Material Accessibility.** We will give You identification cards, Certificates, riders, and other necessary materials.

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

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

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

16. **Premium Refund.** We will give any refund of Premiums, if due, to You.

17. **Recovery of Overpayments.** On occasion, a payment will be made to You when You are not covered, for a service that is not covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

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

19. **Reinstatement After Default.** If You default in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Contract, but with respect to sickness and injury, only to Cover such sickness as may be first manifested more than 10 days after the date of such acceptance

20. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will make or will not make payments under this Contract. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether surgery was Medically Necessary to treat Your illness or injury; or whether certain services are skilled care. Those standards will not be contrary to the descriptions in this Contract. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Contract.

21. **Right to Offset.** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe to Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

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

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

for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

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

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

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

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

26. **Translation Services.** Translation services are available under this Contract for non-English speaking Members. Please contact us at 888.990.5702 to access these services.

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

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

29. **Who May Change This Contract.** The Contract may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer (CEO) or a person designated by the

CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the Contract in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

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

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

32. **Your Medical Records and Reports.** In order to provide Your coverage under this Contract, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Contract, You automatically give Us or our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:
    - Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
    - Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
    - Permit copying of Your medical records by Us.

    We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Contract, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

PrimarySelect EPO Silver I Plan Schedule of Benefits
Silver

COST-SHARING	**Preferred Member Responsibility for Cost-Share**	**Participating Member Responsibility for Cost-Share**	**Non-Participating Member Responsibility for Cost-Share**	
Deductible ● Individual ● Family	$2,000 $4,000	$2,000 $4,000	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Out-of-Pocket Limit ● Individual ● Family	$6,350 $12,700	$6,350 $12,700		
OFFICE VISITS	**Preferred Member Responsibility for Cost-Sharing**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$0 Copayment with your selected doctor	$30 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Specialist Office Visits (or Home Visits)	$75 Copayment	$75 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
PREVENTIVE CARE	**Preferred Member Responsibility for Cost-Sharing**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
● Well Child Visits and Immunizations*	Covered in full	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
● Adult Annual Physical Examinations*	Covered in full	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

• Adult Immunizations*	Covered in full	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Mammography Screenings*	Covered in full	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Sterilization Procedures for Women*	Covered in full	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Vasectomy	Covered in full	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Bone Density Testing*	Covered in full	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Screening for Prostate Cancer	Covered in full	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• All other preventive services required by USPSTF and HRSA.	Covered in full	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• *When preventive	$0 Primary Care Physician when	$30 Primary Care Physician Office	Non-Participating Provider Services	

services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	using selected doctor; $75 Specialist Office Copayment	Copayment after Deductible; $75 Specialist Copayment	Are Not Covered and You Pay the Full Cost	
EMERGENCY CARE	**Preferred Member Responsibility for Cost-Sharing**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$150 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	See Benefit For Description
Non-Emergency Ambulance Services **Preauthorization Required**	$150 Copayment after Deductible **Preauthorization Required**	$150 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Emergency Department Copayment / Coinsurance waived if Hospital admission.	$250 Copayment after Deductible	$250 Copayment after Deductible	$250 Copayment after Deductible	See Benefit For Description
Urgent Care Center	$100 Copayment after Deductible	$100 Copayment after Deductible	Non-Participating Provider Services in Our Service Area Are Not Covered and You Pay the Full Cost	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Preferred Member Responsibility for Cost-Sharing**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	$75 Copayment	$75 Copayment	Non-Participating Provider Services in Our Service Area Are Not Covered and You Pay the Full Cost	24 visits per Plan Year
Advanced Imaging Services ● Performed in a Freestanding	$75 Copayment	$75 Copayment	Non-Participating Provider Services in	See Benefit For Description

Radiology Facility or Office Setting ● Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Our Service Area Are Not Covered and You Pay the Full Cost Non-Participating Provider Services in Our Service Area Are Not Covered and You Pay the Full Cost	
Allergy Testing & Treatment	$30 Primary Care Office Copayment after Deductible; $75 Specialist Office Copayment; 20% Coinsurance after Deductible Surgery; $75 Laboratory & Diagnostic Procedures Copayment	$30 Primary Care Office Copayment after Deductible; $75 Specialist Office Copayment; 20% Coinsurance after Deductible Surgery; $75 Laboratory & Diagnostic Procedures Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Ambulatory Surgical Center Facility Fee	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Anesthesia Services (all settings)	Covered in full; no deductible and no cost sharing applies	Covered in full; no deductible and no cost sharing applies	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Autologous Blood Banking	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Cardiac & Pulmonary Rehabilitation ● Performed in a Specialist Office	$30 Copayment	$30 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating	See Benefit For Description

• Performed as Outpatient Hospital Services	$30 Copayment	$30 Copayment	Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Inpatient Hospital Services	Included as Part of Inpatient Hospital Services Cost-Sharing	Included as Part of Inpatient Hospital Services Cost-Sharing	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Chemotherapy • Performed in a PCP Office	$30 Copayment after Deductible	$30 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed in a Specialist Office	$30 Copayment after Deductible	$30 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	$30 Copayment after Deductible	$30 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Chiropractic Services	$75 Copayment	$75 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office	$75 Copayment	$75 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed in a Specialist Office	$75 Copayment	$75 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital	$75 Copayment	$75 Copayment	Non-Participating Provider Services	

Services			Are Not Covered and You Pay the Full Cost	
Dialysis ● Performed in a PCP Office ● Performed in a Freestanding Center or Specialist Office Setting ● Performed as Outpatient Hospital Services **Preauthorization Required**	$30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible **Preauthorization Required**	$30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible **Preauthorization Required**	$30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible **Preauthorization Required**	See Benefit For Description **Special Limits Apply To Services Provided Out Of The Service Area**
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment	$30 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 visits per condition, per lifetime combined therapies
Home Health Care **Preauthorization Required**	$30 Copayment after Deductible **Preauthorization Required**	$30 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	40 Visits per Plan Year
Infertility Services **Preauthorization Required**	$30 Primary Care Office Copayment after Deductible; $75 Specialist Office Copayment; 20% Coinsurance after Deductible Surgery; $75 Laboratory & Diagnostic Procedures Copayment **Preauthorization Required**	$30 Primary Care Office Copayment after Deductible; $75 Specialist Office Copayment; 20% Coinsurance after Deductible Surgery; $75 Laboratory & Diagnostic Procedures Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Infusion Therapy ● Performed in a PCP Office ● Performed in Specialist Office ● Performed as Outpatient Hospital Services ● Home Infusion Therapy **Preauthorization Required**	$30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible **Preauthorization Required**	$30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	$0 Copayment after Deductible	$0 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Laboratory Procedures ● Performed in a PCP Office ● Performed in a Freestanding Laboratory Facility or Specialist Office ● Performed as Outpatient Hospital Services	$75 Copayment $75 Copayment $75 Copayment	$75 Copayment $75 Copayment $75 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Maternity & Newborn Care ● Prenatal Care	Covered in full	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
● Inpatient Hospital Services and Birthing Center	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
● Physician and Nurse Midwife Services for Delivery	$100 Copayment after Deductible	$100 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
● Breast Pump	Rental Covered in Full	Rental Covered in Full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	20% Coinsurance after Deductible **Preauthorization Required**	20% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Preadmission Testing	$0 Copayment after Deductible	$0 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Diagnostic Radiology Services ● Performed in a PCP Office	$75 Copayment	$75 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
● Performed in a Freestanding Radiology Facility or Specialist Office	$75 Copayment	$75 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating	

• Performed as Outpatient Hospital Services **Preauthorization Required**	$75 Copayment **Preauthorization Required**	$75 Copayment **Preauthorization Required**	Provider Services Are Not Covered and You Pay the Full Cost	
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services **Preauthorization Required**	$75 Copayment 20% Coinsurance after Deductible **Preauthorization Required**	$75 Copayment 20% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy, or Speech Therapy)	$30 Copayment	$30 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 visits per condition, per lifetime combined therapies. See Benefit For Description
Second Opinions on the Diagnosis of Cancer, Surgery, & Other	$75 Copayment	$75 Copayment	Second Opinions on Diagnosis of Cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist when a Referral is obtained. Referral Required	See Benefit For Description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery	$100 Copayment/ case	$100 Copayment/ case	Non-Participating Provider Services Are Not Covered	See Benefit For Description **All**

			and You Pay the Full Cost	**Transplants Must be Performed at Designated Facilities**
• Outpatient Hospital Surgery	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Surgery Performed at an Ambulatory Surgical Center	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Office Surgery	$30 Primary Care Physician Office Copayment; $75 Specialist Office Copayment	$30 Primary Care Physician Office Copayment; $75 Specialist Office Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Preauthorization Required	**Preauthorization Required**	**Preauthorization Required**		
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Preferred Member Responsibility for Cost-Sharing**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$30 Copayment after Deductible	$30 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$30 Copayment Per Device after Deductible	$30 Copayment Per Device after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Diabetic Supplies, Education & Self-Management • Diabetic Supplies and Insulin (30-Day Supply)	$0 Copayment	$0 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Diabetic Education	$0 Copayment	$0 Copayment	Non-Participating	

			Provider Services Are Not Covered and You Pay the Full Cost	
Durable Medical Equipment & Braces	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
External Hearing Aids	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Limited to Single Purchase Once Every 3 Years
Cochlear Implants	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Hospice Services ● Inpatient ● Outpatient **Preauthorization Required**	20% Coinsurance $30 Copayment after Deductible **Preauthorization Required**	20% Coinsurance $30 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Prosthetic Devices ● External	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the	One prosthetic device, per limb, per lifetime

• Internal	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Preferred Member Responsibility for Cost-Sharing**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required**	20% Coinsurance after Deductible **Preauthorization Required**	20% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Observation Stay	$250 Copayment after Deductible	$250 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) **Preauthorization Required**	20% Coinsurance after Deductible **Preauthorization Required**	20% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech, & Occupational therapy)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 consecutive days per Condition per lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Preferred Member Responsibility for Cost-Sharing**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required.**	20% Coinsurance after Deductible **Preauthorization Required.**	20% Coinsurance after Deductible **Preauthorization Required.**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

However, Preauthorization is Not Required for Emergency Admissions	**However, Preauthorization is Not Required for Emergency Admissions**	**However, Preauthorization is Not Required for Emergency Admissions**		
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services	$0 Copayment per admission	$0 Copayment per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions**	20% Coinsurance after Deductible **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions**	20% Coinsurance after Deductible **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Outpatient Substance Use Services	$0 Copayment per admission	$0 Copayment per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS	**Preferred Member Responsibility for Cost-Sharing**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy				
30 Day Supply Tier 1	$0 Copayment	$0 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	$35 Copayment after Deductible	$35 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	$70 Copayment after Deductible	$70 Copayment after Deductible	Non-Participating Provider Services Are Not Covered	

			and You Pay the Full Cost	
Mail Order Pharmacy				
90 Day Supply Tier 1	$0 Copayment	$0 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	$88 Copayment after Deductible	$88 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	$175 Copayment after Deductible	$175 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
WELLNESS BENEFITS	**Preferred Member Responsibility for Cost-Sharing**	**Participating Member Responsibilities for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Gym Reimbursement	$200 per 6 month period; an additional $100 per 6 month period for spouse	$200 per 6 month period; an additional $100 per 6 month period for spouse	**Non-Participating Member Responsibility for Cost-Sharing**	Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse
PEDIATRIC DENTAL & VISION CARE	**Preferred Member Responsibility for Cost-Sharing**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Vision Care • Exams	$30 Copayment after Deductible	$30 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One exam per 12-month period; one prescribed lenses & frames in a 12-month period

• Lenses & Frames	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Contact Lenses	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	