This is Your

PREFERRED PROVIDER ORGANIZATION
BASIC MEDICAL CERTIFICATE OF COVERAGE

Issued by

EmblemHealth Plan, Inc.
55 Water Street
New York, New York 10041

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between EmblemHealth Plan, Inc. (hereinafter referred to as "We", "Us" or "Our"), and the Group listed in the Group Contract. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

The insurance evidenced by this Certificate meets minimum standards for basic medical insurance as defined by the New York State Department of Financial Services. It does not provide basic hospital insurance or major medical insurance.

This Certificate covers only the medical, surgical and other services listed as covered in this Certificate. Except as specifically provided otherwise, it does not cover Hospital or Facility services, Hospitalization, Hospital Outpatient Care, or hospice services.

This Certificate is not a Medicare supplement plan. If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare*. Also, please review the section of this Certificate entitled Coverage for Medicare-Eligible Individuals. Your benefits and Covered Services may be different than those described in other parts of this Certificate.

This Certificate replaces any Certificate(s) and rider(s) previously issued to you.

This Certificate offers You the option to receive Covered Services on three benefit levels:

1. **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 CBP network. You should always consider receiving health services first through Preferred Providers in Our CBP network when available. Preferred Providers may not be available for all Covered Services. Not all Participating Providers are Preferred Providers.

2. **In-Network Benefits.** In-network benefits are the intermediate level of coverage available and the highest level of coverage available for Covered Services that are not available from Preferred Providers. In-network benefits apply when Your care is provided by Participating Providers that are not Preferred Providers and are in Our CBP network. You should always consider receiving health care services first through Preferred Providers and then from Participating Providers that are not Preferred Providers.

3. **Out-of-Network Benefits.** The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge. Some Covered Services, such as home infusion and prescription drugs, are only Covered when received from Participating Providers and are not Covered as out-of-network benefits. See the Schedule of Benefits section of this Certificate for more information.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

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

Karen M.Ignagni
President

If You need foreign language assistance to understand this Certificate, You may call Us at the number on the back of Your ID card.

Out-of-Network Cost Notice

This Certificate gives You the freedom to choose in-network or out-of-network doctors. You can see any network doctor without a referral. Covered Services from out-of-network doctors have deductibles and coinsurance. Payment for Covered Services provided by out-of-network providers is made directly to you under the NYC Non-Participating Provider Schedule of Allowable Charges ("Allowed Amount"). *The Allowed Amount(s) is not related to usual and customary rates or to what the provider may charge but are set at a fixed amount based on EmblemHealth Plan Inc.'s 1983 reimbursement rates. Most of the reimbursement rates have not increased since that time, and will likely be less (and in many instances substantially less) than the fee charged by the out-of-network provider.* You will be responsible for any difference between the provider's fee and the amount of the reimbursement; therefore, you may have a substantial out-of-pocket expense.

Estimate of your out-of-pocket costs for care from out-of-network providers.
If You intend to use an out-of-network provider, You can obtain an estimate of the out-of-network Allowed Amount for the anticipated medical procedure by utilizing EmblemHealth 's CBP Allowance Calculator, which is available online in the CBP members' section at *www.EmblemHealth.com*, or by calling EmblemHealth Member Services at (800) 624-2414. Prior to utilizing the CBP Allowance Calculator or calling Member Services, You must obtain from the out-of-network provider the medical procedure code(s) (CPT Codes) for the service(s) you anticipate receiving. Below are some examples of what You would typically pay out of pocket if you were to receive care or services from an out-of-network provider.

TYPICAL OUT-OF-POCKET COSTS FROM RECEIVING CARE FROM OUT-OF-NETWORK PROVIDERS	
Established Patient Office Visit (typically 15 minutes) — CPT Code 99213	
Estimated Charge for a Doctor in Manhattan	$300
Reimbursement Under the Schedule--	-- $36
Member Out-of-Pocket Responsibility	$264
Routine Maternity Care and Delivery — CPT Code 59400	
Estimated Charge for a Doctor in Manhattan	$12,380
Reimbursement Under the Schedule	-- $1,379
Member Out-of-Pocket Responsibility	$11,001

Total Hip Replacement Surgery — CPT Code 27130	
Estimated Charge for a Doctor in Manhattan	$25,462
Reimbursement Under the Schedule	-- $3,011
Member Out-of-Pocket Responsibility	$22,415

Estimated Charge is set at FAIR Health's 80th percentile and is based on Manhattan zip codes with a 100 prefix.

Please note that deductibles may apply and that You could be eligible for additional reimbursement if Your catastrophic coverage kicks in or you have purchased the Enhanced Non-Participating Provider Schedule, an Optional Rider benefit that provides lower out-of-pocket costs for some surgical and in-hospital services from out-of-network doctors. The Optional Rider Enhanced Non-Participating Provider Schedule increases the reimbursement of the basic program's non-participating provider fee schedule for some in-hospital services on average by 75%.

TABLE OF CONTENTS

End of Certificate

SECTION I

Definitions

Defined terms will appear capitalized throughout this Certificate. Not all services defined below are Covered Services, and not all provider types defined below are eligible providers to deliver services Covered under this Certificate.

Acute: The onset of disease or injury, or a 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 the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated. If your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

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.

Certificate: This Certificate issued by EmblemHealth Plan Inc., including the Schedule of Benefits and any attached riders.

Child, 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 Certificate.

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. The amount can vary by the type of Covered Service.

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 Copayments, Deductibles and/or Coinsurance.

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

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Durable Medical Equipment 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"): 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
- 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 that, within reasonable medical probability, 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 New York State Department of Financial Services to perform external appeals in accordance with New

York law.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under New York Public Health Law Article 28 (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program. Please review this Certificate to find out whether services of a particular type of Facility are Covered.

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

Group: The employer or party that has entered into an agreement with Us as a contract holder.

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 and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York 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 Certificate.

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 New York Public Health Law Article 40 or under a similar certification process required by the state in which the hospice organization is located. This Certificate does not Cover Hospice Care. It may be covered under Your Hospital Plan.

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 (R.N.);
- 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 42 U.S.C. Section 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.

Hospital Plan: The Empire Blue Cross Blue Shield hospital plan that You receive when You enroll in this plan. The Hospital Plan generally pays for services typically Covered under a basic hospital insurance policy and this plan generally pays for services typically Covered under a basic medical insurance policy.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider or to a Preferred Provider. The amount can vary by the type of Covered Service.

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

In-Network Cost-Sharing: Amounts You must pay to a Participating Provider or to a Preferred Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Participating Providers or Preferred Providers. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service that You owe before We

begin to pay for a particular Covered Service.

In-Network 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 received from Participating Providers or Preferred Providers. This limit never includes Your Premium or services We do not Cover.

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

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

Member: The Subscriber or a covered Dependent 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.

Network: The Providers We have contracted with to provide health care services to You.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network 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 Non-Participating Provider. The amount can vary by the type of Covered Service.

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

Out-of-Network Cost-Sharing: Amounts You must pay to a Non-Participating Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before Copayments or Coinsurance, if any, are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service (e.g., a Durable Medical Equipment Deductible) that You owe before We begin to pay for a particular Covered Service.

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 at www.emblemhealth.com 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 calendar year ending on December 31 of each year. The Group Contract Renewal Date is July 1 of each year, but benefits, benefit maximums and Cost-Sharing accumulations under this Certificate are calculated on a calendar year basis.

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

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 ("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.

Primary Care Physician ("PCP"): A participating Physician or nurse practitioner who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this Certificate that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member.

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 and speech therapy in an inpatient or outpatient setting.

Schedule of Benefits: The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization 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 State of New York.

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, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities. Skilled Nursing Facility services are not covered under this Certificate. They may be covered under Your Hospital Plan.

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. Spouse also includes a domestic partner.

Subscriber: The person to whom this Certificate is issued.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. The Allowed Charge(s) payable under this Certificate are not based on UCR.

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 Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: EmblemHealth Plan, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: The review to determine whether services are or were Medically

Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II

How Your Coverage Works

A. Your Coverage Under this Certificate.

Your employer (referred to as the "Group") has purchased a Group health insurance Contract from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

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

- Medically Necessary;
- Provided by a Preferred or Participating Provider for in-network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
- Received while Your Certificate is in force.

C. Participating Providers.

To find out if a Provider is a Preferred or Participating Provider:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website at www.emblemhealth.com.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken;
- Whether the Provider is a Preferred Provider; and
- Whether the Participating Provider is accepting new patients.

You are only responsible for any In-Network Cost-Sharing that would apply to the Covered Services if You receive Covered Services from a Provider who is not a Participating Provider in the following situations:

- The Provider is listed as a Participating Provider in Our online Provider directory;
- Our paper Provider directory listing the Provider as a Participating Provider is incorrect as of the date of publication;
- We give You written notice that the Provider is a Participating Provider in response to Your telephone request for network status information about the Provider; or
- We do not provide You with a written notice within one (1) business day of Your telephone request for network status information.

In these situations, if a Provider bills You for more than Your In-Network Cost-Sharing and You pay the bill, You are entitled to a refund from the Provider, plus interest.

D. Preferred Providers.
Some Participating Providers are also Preferred Providers. Certain services may be obtained from Preferred Providers. If You receive Covered Services from Preferred Providers, Your Cost-Sharing may be lower than if You receive the services from Participating Providers. See the Schedule of Benefits section of this Certificate for coverage of Preferred Provider services.

E. The Role of Primary Care Physicians.
This Certificate does not have a gatekeeper, usually known as a Primary Care Physician ("PCP"). Although You are encouraged to receive care from Your PCP, You do not need a Referral from a PCP before receiving Specialist care.

F. Access to Providers and Changing Providers.
Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are an EmblemHealth CBP Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Group or Member ID number. When You go to the Provider's office, bring Your ID card with You.

To contact Your Provider after normal business hours, call the Provider's office. You will be directed to Your Provider, an answering machine with directions on how to obtain services, or another Provider. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve an authorization to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our Network that meets the time and distance standards and Your care has been transitioned to that

Participating Provider. 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.

G. Out-of-Network Services.
We Cover the services of Non-Participating Providers. However, some services are only Covered when You go to a Participating Provider. See the Schedule of Benefits section of this Certificate for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services unless specifically provided otherwise.

H. Services Subject to Preauthorization.
Our Preauthorization is required before You receive certain Covered Services. Your Preferred or Participating Provider is responsible for requesting Preauthorization for in-network services and You are responsible for requesting Preauthorization for the out-of-network services listed in the Schedule of Benefits section of this Certificate.

I. Preauthorization / Notification Procedure.
If You seek coverage for services that require Preauthorization or notification, You or Your Provider must call the NYC Healthline at 1-800-521-9574 or for certain services, Us or Our vendor at the number on Your ID card.

You or Your Provider must contact NYC Healthline to request Preauthorization as follows:

- At least two (2) weeks prior to a surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.

- At least two (2) 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 an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.

- Except as specifically provided otherwise below, prior to receiving services that the Schedule of Benefits at the end of this Certificate states require Preauthorization.

Please refer to Your Hospital Plan for information about Preauthorization required for Hospital Plan services.

You or Your Provider must contact Us prior to receiving the following services to request Preauthorization:

- Home health care
- Home infusion therapy

- MRI, MRA, PET scan, CAT scan, nuclear cardiology
- Nutritional supplements and enteral formulas

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 which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

J. Failure to Seek Preauthorization.
If You fail to seek Our Preauthorization for out of network benefits subject to this section, We will pay an amount of $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 cost for services. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

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

L. Medical Necessity.
We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, 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;

- 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 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.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

M. Protection from Surprise Bills.

1. Surprise Bills. A surprise bill is a bill You receive for Covered Services in the following circumstances:

- For services performed by a non-participating Provider at a participating Hospital or Ambulatory Surgical Center, when:
    - A participating Provider is unavailable at the time the health care services are performed;
    - A non-participating Provider performs services without Your knowledge; or
    - Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Provider is available and You elected to receive services from a non-participating Provider.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a referral to a Non-Participating Provider means:
    - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;

- The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
- For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your In-Network Cost-Sharing. The Non-Participating Provider may only bill You for Your In-Network Cost-Sharing. You can sign a form to let Us and the Non-Participating Provider know You received a surprise bill.

The form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at www.emblemhealth.com for a copy of the form. You need to mail a copy of the form to Us at the address on Our website or on Your ID card and to Your Provider.

2. **Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

N. Delivery of Covered Services Using Telehealth.

If Your Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

O. Important Telephone Numbers and Addresses.

- CLAIMS
  Submit claim forms to this address(es).
  P.O. Box 3000, NY, NY 10116-3000
  Submit electronic claim forms to:
  PPOEmblemHealthClaim@emblemhealth.com

- COMPLAINTS AND GRIEVANCES
  Submit written Complaints and Grievances to this address(es):
  Grievance & Appeals Dept., P.O. Box 1701, NY, NY 10023-9476

Or call:
1-877-842-3625
TTY/TDD for hearing impaired 711

- UTILIZATION REVIEW APPEALS
  Oral Utilization Review Appeals or Expedited Appeals may be initiated by calling:
  For utilization review decisions made by NYC Healthline, call 1-800-521-9574
  For utilization review decisions made by US, call toll free 888-906-7668.

- SURPRISE BILL CERTIFICATION FORM
  Submit surprise bill certification forms for surprise bills to this address:

  EmblemHealth
  Correspondence Dept.
  P.O. Box 2857
  New York, NY 10116-2857

- MEMBER SERVICES
  Call the number on Your ID card or 212-501-4444
  or 1-877-842-3625 TTY/TDD for hearing impaired 711
  Member Services Representatives are available Monday to Friday, 8 am to 6 pm EST (closed on weekends).

- PREAUTHORIZATION
  For services that require Preauthorization through NYC Healthline:
  Call 1-800-521-9574
  For services that require Preauthorization by Us, call 1-877-846-3625, or
  Medical Services: 1-888-906-7668
  Mental Health and Substance Abuse Services: 1-866-208-1424
  Or write to Us at: Utilization Review Dept., P.O. Box 2809, NY, NY 10116-2809

- OUR WEBSITE
  www.emblemhealth.com

SECTION III

Access to Care and Transitional Care

A. Authorization 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 an authorization to an appropriate Non-Participating Provider. Your Participating Provider or You must request

prior approval of the authorization to a specific Non-Participating Provider. Approvals of authorizations to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will be Covered as an out-of-network benefit if available.

B. When Your Provider Leaves the Network.

If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may 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, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must 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 provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care and obtaining Preauthorization, authorizations, and a treatment plan approved by Us. 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.

C. 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 Certificate 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 Certificate. 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 Certificate 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 and obtaining Preauthorization, authorizations, 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

Providers will ask You to pay Cost-Sharing for each Covered Service You have during a visit. For example, if You have an x-ray during a doctor's visit, You will be asked for Cost-Sharing for both the x-ray and the visit. The Cost-Sharing that applies depends on the service(s) You receive. Please refer to the Schedule of Benefits section of this Certificate for information about the Cost-Sharing terms that apply to Covered Services.

A. Deductible.
Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered in-network and out-of-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 Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the Schedule of Benefits section of this Certificate in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.**

The Deductible runs from January 1 to December 31 of each calendar year.

Note that You may have a separate Deductible(s) for certain types of Covered Services. The separate Deductible(s) may or may not be a combined in-network and out-of-

network Deductible. Please see the Schedule of Benefits section of this Certificate for more information.

If You have a separate Deductible(s) for a particular Covered Service, You must pay the separate Deductible amount for that particular type of Covered Service in each Plan Year before We will provide coverage for that type of Covered Service. Payments for out-of-network services of that type do not apply to a separate in-network Deductible. Payments for in-network services of that type do not apply to a separate out-of-network Deductible. However, if the separate Deductible is also a combined in-network and out-of-network Deductible, then Your payments in each Plan Year for the particular type of Covered Service will apply to the separate Deductible regardless of whether the Covered Service is performed by a Participating or Non-Participating Provider.

Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the separate Deductible. Amounts You pay towards Deductibles for other Covered Services under this Certificate also do not apply toward the separate Deductible.

B. Copayments.
Except where stated otherwise, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Certificate for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

You are responsible to pay more than one Copayment per Provider on the same day if the Provider performs more than one service. However, You are not responsible to pay more than two (2) Copayments per Participating Provider per day.

C. Coinsurance.
Except where stated otherwise, after You have met any applicable Deductible, You may be required to pay a percentage of the Allowed Amount for Covered Services as shown in the Schedule of Benefits section of this Certificate. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits section of this Certificate. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

D. In-Network Out-of-Pocket Limit.
When You have met Your In-Network Out-of-Pocket Limit in payment of In-Network Cost-Sharing for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered in-network Services for the remainder of that Plan Year. If You have other than individual coverage, the individual In-Network Out-of-Pocket Limit applies to each person covered under this Certificate. Once a person within a family meets the individual In-Network Out-of-Pocket Limit, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family In-

Network Out-of-Pocket Limit in payment of In-Network Cost-Sharing for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family. In-network Cost-Sharing amounts to which an Out-of-Pocket Limit applies will accumulate toward both the Out-of-Pocket Limits for Preferred Providers and for Participating Providers.

Cost-Sharing for out-of-network services, except for Emergency Services (to the extent Covered under this Certificate) and out-of-network services approved by Us as an in-network exception, does not apply toward Your In-Network Out-of-Pocket Limit. The Preauthorization notification penalty described in the How Your Coverage Works section of this Certificate does not apply toward Your In-Network Out-of-Pocket Limit. The In-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

E. No Out-of-Network Out-of-Pocket Limit.
This Certificate does not have an Out-of-Network Out-of-Pocket Limit. However, this Certificate does provide Catastrophic Benefits for certain Covered Services You receive from Non-Participating Providers after you meet the catastrophic threshold. Please refer to the Catastrophic Coverage for Certain Out-of-Network Services section of this Certificate for more information.

F. Your Additional Payments for Out-of-Network Benefits.
When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the Schedule of Benefits section of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one (1) inclusive payment in that case rather than a separate payment for each billed code. Another example of when We will apply the payment rules to a claim is when You have surgery that involves two (2) surgeons acting as "co-surgeons". Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If We receive a claim that does not have the correct modifier, We will change it and make the appropriate payment. Additionally, another example of when We will apply a payment rule to a claim is when You receive services from a Health Care Professional who not a Physician, such as a physician's assistant. Under the payment rule, the Allowed

Charge for a physician's assistant or other Health Care Professional who is not a Physician will be less than the Allowed Amount for Physician.

G. Allowed Amount.
"Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Preferred and Participating Providers will be the amount We have negotiated with the Provider, or the Provider's charge, if less.

The Allowed Amount for Non-Participating Providers will be determined as follows:

1. **Facilities.**
   For Non-Participating Facilities rendering mental health or substance use services, the Allowed Amount will be the lesser of the average amount paid by Us for comparable services to participating Facilities in the same county or if there are no participating Hospitals and/or Facilities in the same county, then the average amount paid by Us for comparable services to participating Facilities in the contiguous county or counties or the Facility's charge.

   For other Non-Participating Facilities, the Allowed Amount will be the lesser of the NYC Non-Participating Facility Schedule of Allowable Charges or the Facility's charge.

2. **Providers of Durable Medical Equipment and Braces, Medical Supplies and External Prosthetics.** For Providers of Durable Medical Equipment and braces, medical supplies and external prosthetics, the Allowed Amount will be the lesser of 50% of the Participating Provider Allowed Amount or the Provider's charge.

3. **For All Other Providers.**
   For all other Non-Participating Providers, the Allowed Amount will be the lesser of the NYC Non-Participating Provider Schedule of Allowable Charges; or the Provider's charge.

Our Allowed Amount(s) is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Allowed Amounts for most services are based on Our 1983 reimbursement rates. Most of the reimbursement rates have not increased since that time. They will typically be less (and in many instances substantially less) than the fee charged by the Non-Participating Provider. Contact Us at the number on Your ID card or visit Our website at www.emblemhealth.com for information on Your financial responsibility when You receive services from a Non-Participating Provider. See also the Out of Network Cost Notice at the front of this Certificate.

We reserve the right to negotiate a lower rate with Non-Participating Providers. If the Provider participates in a network for an equivalent product offered by an affiliated insurer or HMO in another state, We reserve the right to pay the rate the Provider has agreed to accept from the other insurer or HMO.

See the Emergency Services and Urgent Care section of this Certificate for the Allowed Amount for Covered Services relating to an Emergency Condition.

SECTION V

Who is Covered

A. Who is Covered Under this Certificate.

You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

2. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Certificate.

If You selected family coverage, Children covered under this Certificate 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 a 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 permanent legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are not covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability (as defined in the New York 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

thirty-one (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 Certificate at any time.

D. When Coverage Begins.
Coverage under this Certificate will begin as follows:

1. If You, the Subscriber, elect coverage before becoming eligible, or within thirty (30) days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group. Groups cannot impose waiting periods that exceed ninety (90) days.

2. If You, the Subscriber, do not elect coverage upon becoming eligible or within thirty (30) days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.

3. If You, the Subscriber, marry while covered, and We receive notice of such marriage and any Premium payment within thirty (30) days thereafter, coverage for Your Spouse starts on the first day of the following month after We receive Your application. If We do not receive notice within thirty (30) days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse.

4. If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within thirty (30) days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive 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 thirty (30) 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, We 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 notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within thirty (30) 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 We receive notice, provided that You pay any additional Premium when due.

E. Special Enrollment Periods.

You, Your Spouse or Child can also enroll for coverage within thirty (30) days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment;

2. Termination of the other group health plan;

3. Death of the Spouse;

4. Legal separation, divorce or annulment;

5. Reduction of hours of employment;

6. Employer contributions toward the group health plan were terminated for You or Your Dependents' coverage; or

7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll thirty (30) days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoption.

We must receive notice and Premium payment within thirty (30) days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

In addition, You, Your Spouse or Child, can also enroll for coverage within sixty (60) days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or Child Health Plus; or

2. You or Your Spouse or Child becomes eligible for Medicaid or Child Health Plus.

We must receive notice and Premium payment within 60 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

F. Domestic Partner Coverage.
This Certificate covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this Certificate also include the Children of Your domestic partner. Proof of the domestic partnership 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 (6) 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 18 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 (6) months;
    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 (2) 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 (1) 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; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI

Preventive Care

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

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 or Coinsurance) when performed by a Preferred or 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 the number on Your ID card or visit Our website at

www.emblemhealth.com 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.

A. **Well-Baby and Well-Child Care.** We Cover well-baby and well-child care which consists 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 (1) 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 Preferred or Participating Provider.

B. **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, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening and diabetes screening. A complete list of the Covered preventive Services is available on Our website at www.emblemhealth.com or will be mailed to You upon request.

   You are eligible for a physical examination once every calendar 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 Preferred or Participating Provider.

C. **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 Preferred or Participating Provider.

D. **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 www.emblemhealth.com, 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, which may be less frequent than described above, and when provided by a Preferred or Participating Provider.

E. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We Cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39;
- Upon the recommendation of the Member's Provider, an annual screening mammogram for Members age 35 through 39 if Medically Necessary; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Preferred or Participating Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance when provided by a Preferred or Participating Provider.

F. Family Planning and Reproductive Health Services. We Cover family planning services which consist of: FDA-approved, -cleared or -granted contraceptive methods prescribed by a Provider not otherwise Covered under the Prescription Drug Coverage section(s) of this Certificate, patient education and counseling on use of contraceptives and related topics, follow up services related to contraceptive methods, including management of side effects, counseling for continued adherence, device insertion and removal, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided by a Preferred or Participating Provider.

We Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

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

G. Bone Mineral Density Measurements or Testing. We Cover bone mineral density measurements or tests. Bone mineral density measurements or tests shall include those covered under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- 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 osteoporosis screening 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 by a Preferred or Participating Provider and 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.

H. 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 a Preferred or Participating Provider.

I. Colon Cancer Screening. We Cover colon cancer screening for Members age 45 through 75, including all colon cancer examinations or laboratory tests in accordance with the USPSTF and any additional screenings recommended by the American Cancer Society Guidelines for average risk individuals. This benefit includes an initial colonoscopy or other medical test for colon cancer screening

and a follow-up colonoscopy performed because of a positive result from a non-colonoscopy preventive screening test.

This benefit is not subject to Cost-Sharing when provided in accordance with the recommendations of the USPSTF and when provided by a Preferred or Participating Provider, but may be subject to Cost-Sharing for additional screenings provided in accordance with the American Cancer Society Guidelines.

SECTION VII

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. Pre-Hospital Emergency Medical Services. We Cover Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York 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 licensed under New York Public Health Law Article 30 must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment,

Deductible or Coinsurance.

In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the lesser of the FAIR Health rate at the 80th percentile calculated using the place of pickup or the Provider's billed charges.

2. Emergency Ambulance Transportation. In addition to Pre-Hospital Emergency Medical Services, We also Cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground or water ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

In the absence of negotiated rates, We will pay a Non-Participating Provider licensed under New York Public Health Law Article 30 the usual and customary charge for emergency ambulance transportation, which shall not be excessive or unreasonable. The usual and customary charge for emergency ambulance transportation is the lesser of the FAIR Health rate at the 80th percentile calculated using the place of pickup or the Provider's billed charges.

We will pay a Non-Participating Provider that is not licensed under New York Public Health Law Article 30 the amount We have negotiated with the Non-Participating Provider for the emergency ambulance transportation or an amount We have determined is reasonable for the emergency ambulance transportation. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

B. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition even if prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- We do not Cover air ambulance under any circumstances (emergency or non-emergency).
- We do not Cover non-emergency Hospital to Hospital transport.

SECTION VIII

Emergency Professional Services and Urgent Care

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

A. Emergency Services.
Except as specifically provided otherwise, We do NOT Cover Hospital services, including, but not limited to Emergency Services for the treatment of an Emergency Condition in a Hospital. These services may be covered under Your Hospital Plan.

However, if you receive Covered Services from a Physician or other Provider that is not employed by the Hospital during Your Emergency room or emergency hospital admission and Your Hospital Plan denies payment for those services, benefits are available under this Certificate for those services.

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
- Convulsions

Payments Relating to Emergency Services Rendered.

Most emergency services are covered under Your Hospital Plan, not this Certificate.

To the extent that emergency professional services are covered under this Certificate, the amount We pay to a Preferred or Participating Provider for Covered Services You receive in a Hospital to treat an Emergency Condition will be the amount We have negotiated with the Provider. The amount We pay a Non-participating Provider for Covered Services You receive in a Hospital to treat an emergency condition will be an amount We have negotiated with the Non-Participating Provider for the service or an amount We have determined is reasonable for the service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge. If a dispute involving a payment for physician services relating to emergency services payable by Us is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for physician services.

You are responsible for any In-Network Cost-sharing. You will be held harmless for any Non-Participating Provider charges that exceed Your In-Network Cost-sharing. The Non-Participating Provider may only bill You for Your In-Network Cost-sharing. If You receive a bill from a Non-Participating Provider that is more than Your In-Network Cost-sharing, You should contact Us.

B. 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 in a Hospital. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911**. Urgent Care is Covered in or out of Our Service Area.**

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center.

2. **Out-of-Network.** We Cover Urgent Care from a non-participating Urgent Care Center or Physician.

If Urgent Care results in an emergency admission, the Hospital services are not covered under this Certificate. They may be covered under Your Hospital Plan.

SECTION IX

Professional Services and Certain Outpatient Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that

apply to these benefits.

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

B. 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.

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

D. Chemotherapy, Immunotherapy and Radiation Therapy.
We Cover chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are not Covered under this Certificate. Such drugs may be covered under the City of New York PICA program. We Cover radiation therapy in an outpatient Facility or in a Health Care Professional's office.

E. Chiropractic Services.
We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") or a Physician 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 laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

F. Clinical Trials.
We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Preferred or Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Certificate.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-

investigational treatments provided in the clinical trial.

An “approved clinical trial” means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

G. Habilitation Services.

We Cover Habilitation Services consisting of physical therapy and speech therapy in the outpatient department of a Facility or in a Health Care Professional’s office for up to sixteen (16) visits per Plan Year. The visit limit applies to all therapies combined. We will Cover additional visits if Preauthorization is obtained. We do Not cover occupational therapy except as part of a Covered home health care visit.

H. 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:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription 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 two hundred (200) visits per Plan Year from Participating Providers and forty (40) visits per Plan Year from Non-Participating Providers. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

I. Infertility Treatment.

We Cover services for the diagnosis and treatment (surgical and medical) of infertility. “Infertility” is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member’s medical history or physical findings.

Such Coverage is available as follows:

1. **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.

   Basic infertility services include:
   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultrasound;
   - 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.

2. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

   Comprehensive infertility services include:
   - Ovulation induction and monitoring;
   - Pelvic ultrasound;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

3. **Advanced Infertility Services.** We Cover the following advanced infertility services:
   - Three (3) cycles per lifetime of in vitro fertilization;
   - Cryopreservation and storage of sperm, ova, and embryos in connection with in vitro fertilization.

   A “cycle” is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of

undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

4. **Fertility Preservation Services.** We Cover standard fertility preservation services when a medical treatment may directly or indirectly cause iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Iatrogenic infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

5. **Exclusions and Limitations.** We do not Cover:
    - Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
    - Costs associated with an ovum or sperm donor, including the donor's medical expenses;
    - Ovulation predictor kits;
    - Reversal of tubal ligations;
    - Reversal of vasectomies;
    - Costs for services relating to surrogate motherhood that are not otherwise Covered Services under this Certificate;
    - Cloning; or
    - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

    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. We will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

J. Infusion Therapy.

We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients, including enteral formulas and nutritional supplements, administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected 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, or in the outpatient department of a Hospital.

K. Interruption of Pregnancy.

We Cover abortion services. Coverage for abortion services includes any Prescription Drug prescribed for an abortion, including both Generic Drugs and Brand-Name Drugs, even if those Prescription Drugs have not been approved by the FDA for abortions, if the Prescription Drug is a recognized medication for abortions in one of the following

reference compendia:
• The WHO Model Lists of Essential Medicines;
• The WHO Abortion Care Guidelines; or
• The National Academies of Science, Engineering and Medicine Consensus Study Report.

Abortion services are not subject to Cost-Sharing when provided by a Preferred or Participating Provider.

L. 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 performed out of the Hospital by a Health Care Professional or an independent laboratory. We Cover the separate interpretation of x-rays, diagnostic tests and radiological services when separately billed by a doctor or provider.

M. Maternity and Newborn Care.
We Cover services for maternity care provided by a Physician or midwife, or nurse practitioner. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. We do not cover inpatient maternity care provided by a Hospital, Facility or birthing center. Such services may be covered under Your Hospital Plan.

We Cover breastfeeding support, counseling and supplies, including the cost of renting or the purchase of one (1) breast pump per pregnancy or, if greater, one (1) per calendar year for the duration of breast feeding.

N. Office Visits.
We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls. We cover primary care office visits. We also cover Specialist office visits as set forth below.

O. Prescription Drugs Administered in the Office and Outpatient Facilities.
We Cover prescription drugs and injectables (excluding self-injectables) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You.

P. Rehabilitation Services.
We Cover Rehabilitation Services consisting of physical therapy and speech therapy in

the outpatient department of a Facility or in a Health Care Professional's office for up to sixteen (16) visits per Plan Year. The visit limit applies to all therapies combined. We will Cover additional visits if Preauthorization is obtained. We do Not cover occupational therapy except as part of a Covered home health care visit.
We Cover speech and physical therapy only when:

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

Covered Rehabilitation Services must begin within six (6) 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.

Q. 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 second surgical opinions by a qualified Physician on the need for surgery.

- **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.

R. 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 or a Hospital employee. Anesthesia must be rendered in connection with a surgical or obstetrical services covered under this Certificate or Your Hospital Plan.

Sometimes two (2) or more surgical procedures can be performed during the same operation.

1. **Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, We will pay for the procedure that has the highest Allowed Amount. We will not pay for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. We also will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.

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

Payment for a first assistant surgeon is based upon 20% of the Allowed Amount. Payment for a second assistant surgeon is based upon 10% of the Allowed Amount. A physician's assistant is covered in lieu of an assistant surgeon, Payment for the first physician's assistant is based upon 15% of the Allowed Amount. Payment for a second physician's assistant surgeon is based upon 7.5% of the Allowed Amount.

Our Allowed Amounts for anesthesia include the administration of blood and other fluids and are based on the procedure performed and the amount of time spent by the anesthesiologist.

S. 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 twelve (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. Excision of impacted teeth is not Covered.

- Surgical/nonsurgical medical procedures for temporomandibular joint (TMJ) disorders and orthognathic surgery.

We do not Cover intra-oral appliances or orthopedic devices and their maintenance.

T. Reconstructive Breast Surgery.
We Cover breast or chest wall reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes all stages of reconstruction of the breast or chest wall on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast or chest wall 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. Chest wall reconstruction surgery includes aesthetic flat closure as defined by the National Cancer Institute. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

U. 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;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

V. Telemedicine Program.
In addition to providing Covered Services via telehealth, We Cover online internet consultations between You and Providers who participate in Our telemedicine program for medical conditions that are not an Emergency Condition. Not all Participating Providers participate in Our telemedicine program. You can check Our Provider directory or contact Us for a listing of the Providers that participate in Our telemedicine program.

We also offer a telemedicine benefit with unlimited sessions of video/telephonic or e-visits. The telemedicine vendor provides an online internet consultation over a computer or using a mobile application. Providers can be accessed via mobile application, website and/or telephone.

Provider consultations are for non-emergency medical conditions only. Subject to the Prescription Drug Coverage section of this Certificate, if necessary, the telemedicine Physician may write a prescription and send it to an in-network participating retail pharmacy. Prescriptions are subject to cost-sharing where applicable.

You must create an account with Our telemedicine vendor before You will be given access to the list of participating telemedicine providers. Once access is obtained, You will be able to participate in a telemedicine consultation either online or by telephone

with a telemedicine Provider who is available. Telemedicine Providers are available twenty-four (24) hours/seven (7) days a week.

You are responsible for any Copayment, Deductible or Coinsurance. Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements.

W. Transplants.
We will provide benefits for Covered Services listed in this Certificate in connection with transplants preauthorized under Your Hospital Plan. Transplants include, but are not limited to: kidney, corneal, liver, heart, and lung transplants; and bone marrow transplants.

We Cover the medical expenses of the Member-recipient only if they are listed as Covered Services under this Certificate. We Cover such transplant services required by You when You serve as an organ donor only if the recipient is a Member and the service is otherwise a Covered Service under this Certificate. We do not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program.

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

SECTION X

Additional Benefits, Equipment and Devices

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

A. 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 New York Education Law as described below:

1. **Equipment and 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
- 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
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose kit
- Glucose monitor with or without special features for visually impaired, control solutions, and strips for home glucose monitor
- Glucose reagent tape
- Glucose test or reagent strips
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- 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.

Diabetic equipment and supplies are limited to a thirty (30) day supply up to a maximum of a ninety (90) day supply when purchased at a pharmacy.

2. 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 New York 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 New York 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.

3. 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 or as otherwise Medically Necessary.

Step Therapy for Diabetes Equipment and Supplies. Step therapy is a program that requires You to try one type of diabetic Prescription Drug, supply or equipment unless another Prescription Drug, supply or equipment is Medically Necessary. The diabetic Prescription Drugs, supplies and equipment that are subject to step therapy include:

- Diabetic glucose meters and test strips;
- Diabetic supplies (including but not limited to syringes, lancets, needles, pens);
- Insulin;
- Injectable anti-diabetic agents; and
- Oral anti-diabetic agents.

These items also require Preauthorization and will be reviewed for Medical Necessity. If a step therapy protocol is applicable to Your request for coverage of a diabetic Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this Certificate. We will not add step therapy requirements to a diabetic Prescription Drug on Our Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns.

B. Durable Medical Equipment and Braces.
We Cover the rental or purchase of durable medical equipment and braces.

1. 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
- Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

2. **Braces.**
   We Cover braces, including orthotic 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 repair or replacement that is the result of misuse or abuse by You.

3. **Nutritional Supplements and Enteral Formulas.**
   We Cover the following types of nutritional supplements and enteral formulas when authorized by Us:
   - Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
   - Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, 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. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.
   - 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.

C. Medical Supplies.

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Certificate. 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. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

D. External Prosthetic Devices.
We Cover prosthetic devices 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 external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We also Cover the cost of repair and replacement of the prosthetic device and its parts when prescribed by a physician and required due to normal growth, change in Your condition, loss or irreparable damage. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. We do not Cover eyeglasses and contact lenses. We do not Cover shoe inserts.

We do not Cover internal prosthetic devices, such as surgically implanted prosthetic devices and special appliances to improve or restore the function of an internal body part which has been removed or damaged due to disease or injury, or implanted breast prostheses following a mastectomy or partial mastectomy. These devices may be Covered under Your Hospital Plan.

E. Private Duty Nursing.
We will cover private duty nursing services rendered at home or in a Hospital after you have met a separate Deductible for private duty nursing. The attending doctor must file a statement acceptable to Us that the services are Medically Necessary for You. The doctor must prescribe a plan of skilled nursing care. Your condition must be unstable and require constant monitoring. The services must relate to Your diagnosis and condition.

The services must be performed by a registered nurse, or if a registered nurse is not available and documentation of same is provided to Us, by a licensed practical nurse. Charges for the service must be based on the time spent by the nurse.

This service is not Covered if it could be performed by home health aides, home attendants, similar providers or Your family members.

Custodial care is not covered, even if performed by a registered nurse or licensed nurse practitioner.

SECTION XI

Certain Inpatient Services
(other than Mental Health and Substance Use)

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

Except as specifically provided otherwise, this Certificate generally does not cover inpatient hospital services, including but not limited to inpatient habilitation, maternity or mastectomy care services, observation stays, or autologous blood banking services. These services may be covered under Your Hospital Plan.

A. Inpatient Medical Services.
We Cover medical visits for Covered Services by a Health Care Professional who is not employed by the Hospital on any day that You receive inpatient care while You are Covered under this Certificate.

SECTION XII

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits, which are no more restrictive than those that apply to benefits for other types of conditions in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services. We Cover the following mental health care services to treat a mental health condition. For purposes of this benefit, “mental health condition” means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Certificate and Your Hospital Plan. Coverage for inpatient services for mental health care is

limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- A state or local government run psychiatric inpatient Facility;
- A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

and, in other states, to similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Law Section 30 and, in other states, to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a licensed or certified Facility that provides the same level of treatment, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

2. **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, health conditions. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health, and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law 36.01 and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a licensed nurse practitioner; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

Outpatient mental health care services also include outpatient care provided at a preschool, elementary, or secondary school by a school-based mental health clinic licensed pursuant to Mental Hygiene Law Article 31, regardless of whether the school-based mental health clinic is a Participating Provider. We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the outpatient mental health care services. In the absence of a negotiated rate, We will pay an amount no less than the rate that would be paid under the Medicaid program. However, the negotiated amount or the amount paid under the Medicaid program will not exceed the Non-Participating Provider's charge. The school-based mental health clinic shall not seek reimbursement from You for outpatient services provided at a school-based mental health clinic except for Your In-Network Cost-Sharing.

3. **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.

   • **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 do not Cover items, such as, but not limited to, laptop, 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.

   We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or

theft. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or 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 a licensed or certified applied behavior analysis Health Care Professional. "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.

• **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 New York 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 Certificate. 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 Certificate.

• **Pharmacy Care.** If You have purchased the Optional Rider with Prescription Drug coverage, We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs will be subject to all the terms, provisions, and limitations of the Optional Rider.

• **Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under New York Public Health Law Section 2545 , an individualized education plan under New York Education Law Article 89, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect Coverage under this Certificate 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 Copayment, Deductible or Coinsurance provisions under this Certificate for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit. See the Schedule of Benefits section of this Certificate for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

B. Substance Use Services. We Cover the following substance use services to treat a substance use disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes Coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are certified or otherwise authorized by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs.

   We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment substance use disorders, including but not limited to partial hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling, and medication assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance abuse disorder services, and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01,and, in other states, to those that are licensed, certified or otherwise authorized by a

similar state agency or which are accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction 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.

Additional Family Counseling. We also Cover up to 20 outpatient visits per Plan Year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from substance use disorder; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use disorder. 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.

Section XIII

Certain Prescription Drugs

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, supply limits, and any Preauthorization or medical management requirements that apply to these benefits.

A. Covered Prescription Drugs.

We Cover Medically Necessary Prescription Drugs listed below 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;
- On Our Formulary; and
- Dispensed by a licensed pharmacy.

We Cover the following Prescription Drugs:

1. Prescription drugs that are FDA-approved for the treatment of substance use disorder ("SUD Medications"), including drugs for detoxification and maintenance treatment, all buprenorphine products, methadone, and long-acting injectable naltrexone and opioid overdose reversal medication, including when dispensed over-the-counter.
2. Prescription Drugs prescribed in conjunction with Covered in-vitro fertilization services and fertility preservation services.
3. Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved, cleared, or granted by the FDA and as prescribed or otherwise authorized under State or Federal law.
    a. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").
    b. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product, as determined by Your attending Health Care Professional. You may request an exception by having Your attending Health Care Professional complete the Contraception Exception Form and sending it to Us. Visit Our website at www.emblemhealth.com or call the number on Your ID card to get a copy of the form or to find out more about this exception process.
4. Prescription Drugs to treat diabetes, including insulin, oral hypoglycemics, and diabetic equipment and supplies if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under New York Education Law Title 8.
5. Preventive Prescription Drugs (such as smoking cessation drugs), including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by HRSA or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
6. Prescription drugs for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to prevent HIV infection.

You may request a copy of Our Formulary. Our Formulary is also available on Our website. You may inquire if a specific drug is Covered under this section by contacting Us at the number on Your ID card.

B. Refills

We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order pharmacy and only after ¾ of the original Prescription Drug has been used. Benefits for

Refills will not be provided beyond one (1) year from the original prescription date. Certain drugs must be refilled at a mail order or designated pharmacy.

C. Benefit and Payment Information.

1. **Cost-Sharing Expenses.** Your Cost-Sharing for Prescription Drugs is set forth in Schedule of Benefits section of this Certificate.

   Except as specifically provided otherwise, You have a three (3) 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.

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

   Coupons and Other Financial Assistance. We will count any third-party payments, financial assistance, discounts, or other coupons that help You pay Your Cost-Sharing towards Your In-Network Deductible and In-Network Out-of-Pocket Limit. This provision only applies to:
   - a Brand-Name Drug without an AB-rated generic equivalent, as determined by the FDA;
   - a Brand-Name Drug with an AB-rated generic equivalent, as determined by the FDA, and You have accessed the Brand-Name Drug through Preauthorization or an Appeal, including step-therapy protocol; and
   - all Generic Drugs.

2. **Participating Pharmacies.** For Prescription Drugs purchased at a Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Medication Cost for that 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 claim form. Contact Us at the number on Your ID card or visit Our website to request approval.

3. **Non-Participating Pharmacies.** We will not pay for any Prescription Drugs that You purchase at a Non-Participating Pharmacy other than as described above.

4. **Designated Pharmacies.** We may direct You to a Designated Pharmacy with whom We have an arrangement for certain Prescription Drugs Covered by this Rider, including specialty Prescription Drugs. However, if the Designated Pharmacy is not a retail pharmacy, You may also obtain these Prescription Drugs from a retail pharmacy when that retail pharmacy is a Participating Pharmacy and agrees to the same reimbursement amount as the Designated Pharmacy.

   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, You will not have coverage for that Prescription Drug. However, if the Designated Pharmacy is not a retail pharmacy, You may obtain Your Prescription Drug at a retail Participating Pharmacy that agrees to the same reimbursement amount as the non-retail Designated Pharmacy.

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

   - Oral hypoglycemic agents
   - Insulin
   - Non-insulin diabetic injectables
   - Combination antihyperglycemics
   - Lipid/cholesterol lowering agents
   - Injectable contraceptives
   - Intravaginal contraceptives
   - Prenatal vitamins
   - Certain vitamins & iron

5. **Mail Order.** Except as described below, certain Prescription Drugs must be ordered through Our mail order pharmacy after an initial 30-day supply, with the exception of contraceptive drugs, devices, or products which are available for a 12-month supply. 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 Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order pharmacy 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.

The requirement to obtain certain Prescription Drugs through a mail order pharmacy will not apply and We will provide benefits that apply to Prescription Drugs dispensed by a mail order pharmacy to Prescription Drugs that are purchased from a retail pharmacy when that retail pharmacy is a Participating Pharmacy and agrees to the same reimbursement amount as a participating mail order pharmacy.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at www.emblemhealth.com or by calling the number on Your ID card.

6. **Formulary Changes.** Our Formulary is subject to Our periodic review and modification. However, a Prescription Drug will not be removed from Our Formulary during the Plan Year, except when the FDA determines that such Prescription Drug should be removed from the market. Before We remove a Prescription Drug from Our Formulary at the beginning of the upcoming Plan Year, We will provide at least 90 days' notice prior to the start of the Plan Year. We will also post such notice on Our website at www.emblemhealth.com.

   We will not add utilization management restrictions (e.g., step therapy or Preauthorization requirements) to a Prescription Drug on Our Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns.

7. **Tier Status.** A Prescription Drug will not be moved to a tier with a higher Cost-Sharing during the Plan Year, except a Brand-Name Drug may be moved to a tier with higher Cost-Sharing if an AB-rated generic equivalent or interchangeable biological product for that Prescription Drug is added to the Formulary at the same time. Additionally, a Prescription Drug may be moved to a tier with a higher Copayment during the Plan Year, although the change will not apply to You if You are already taking the Prescription Drug or You have been diagnosed or presented with a condition on or prior to the start of the Plan Year which is treated by such Prescription Drug or for which the Prescription Drug is or would be part of Your treatment regimen.

   Before We move a Prescription Drug to a different tier, We will provide at least 90 days' notice prior to the start of the Plan Year. We will also post such notice on Our website at www.emblemhealth.com. If a Prescription Drug is moved to a different tier during the Plan Year for one of reasons described above, We will provide at least 30 days' notice before the change is effective. You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. You may access the most up to date tier status on Our website at www.emblemhealth.com or by calling the number on Your ID card.

8. Formulary Exception Process.

If a Prescription Drug in a category that is Covered under this section is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of the Certificate. Visit Our website or call the number on Your ID card to find out more about this process.

Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than 72 hours after Our receipt of Your request. We will notify You in writing within three (3) business days of receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than 24 hours after Our receipt of Your request. We will notify You in writing within three (3) business days of receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

9. Supply Limits. Except for contraceptive drugs, devices or products, We will pay for no more than a 30 day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply.

You may have the entire supply (of up to 12 months) of a contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices, or products are not subject to Cost-Sharing.

Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of two and a half (2.5) Cost-Sharing amount(s) for a 90-day supply.

Specialty Prescription Drugs, if any, may be limited to a 30-day supply when obtained at a mail order pharmacy. You may access Our website at www.emblemhealth.com or by calling the number on Your ID card for more information on supply limits for specialty Prescription Drugs.

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 or by calling the 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 the Utilization Review and External Appeal sections of the Certificate.

10. **Emergency Refill During a State Disaster Emergency.** If a state disaster emergency is declared, You, Your designee, or Your Health Care Provider on Your behalf, may immediately get a 30-day Refill of a Prescription Drug You are currently taking. You will pay the Cost-Sharing that applies to a 30-day Refill. Certain Prescription Drugs, as determined by the New York Commissioner of Health, are not eligible for this emergency Refill, including schedule II and II controlled substances.

D. Medical Management. This section 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.

1. **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. Preauthorization is not required for SUD Medications, including opioid overdose reversal medications prescribed or dispensed to You.

   For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.emblemhealth.com or call the 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. However, We will not add Preauthorization requirements to a Prescription Drug on Our Formulary during a Plan Year unless the requirements are added pursuant to

FDA safety concerns. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one (1) or more types of Prescription Drug before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. 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. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of the Certificate. We will not add step therapy requirements to a Prescription Drug on Our Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns.

E. Limitations/Terms of Coverage.

1. 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.

2. 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 do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

3. 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 Prescription 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.

4. Your benefit for diabetic insulin, oral hypoglycemics, and diabetic Prescription Drugs, and diabetic supplies, and equipment will be provided under this section of the Certificate. Other injectable drugs are not Covered under this Certificate. They may be covered under the NYC PICA Program.

5. 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 other sections of the Certificate.

6. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this section. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. We do not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one (1) or more Prescription Drug(s) and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.

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

8. 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.

9. 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 the Utilization Review and External Appeal sections of the Certificate.

10. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

F. General Conditions.

1. 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.

2. Drug Utilization and Cost Management. We reserve the right to 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.

G. Definitions.

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

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

2. **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.

3. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this section. To determine which tier a particular Prescription Drug has been assigned, visit Our website at www.emblemhealth.com or call the number on Your ID card..

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

5. **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.

6. **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
   - Been designated by Us as a Participating Pharmacy.

7. **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. This section covers only the types of Prescription Drugs described herein.

8. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, We have agreed to pay Our Participating Pharmacies or as contracted between Us and Our pharmacy benefit manager for a Covered Prescription Drug dispensed at a Participating Pharmacy.

9. **Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.

10. **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 New York Education Law Section 6826-a.

SECTION XIV

Catastrophic Coverage for Certain Out-of-Network Services.

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements and limits that apply to these benefits.

A. Catastrophic Services.

This Certificate provides additional benefits for certain Covered Services that are received from Non-Participating Providers once your qualifying expenses reach a certain dollar amount. These additional benefits are referred to as “Catastrophic Coverage” or “Catastrophic Benefits.”

If You receive benefits under this Certificate for any of the Covered Service(s) listed below from a Non-Participating Provider(s) and You incur qualifying expenses in a Plan Year that are more than the Catastrophic Threshold(s) set forth in the Schedule of Benefits section of this Certificate, for some or all of those Non-Participating Provider services, We will pay Catastrophic Benefits.

The Covered Services from Non-Participating Providers that are eligible for Catastrophic Benefits include:

- Surgery
- Administration of anesthesia
- Chemotherapy
- Radiation therapy
- Covered Services provided to you during an inpatient Hospital stay.
- Maternity care

These are the only Covered Services that are eligible for Catastrophic Benefits. They are collectively called "Catastrophic Services."

Services received from Non-Participating Providers that are processed as surprise bills or emergency services are not considered Catastrophic Services.

B. Catastrophic Threshold.

This Certificate has a separate Catastrophic Threshold(s). The amount of the Catastrophic Threshold(s) is set forth in the Schedule of Benefits section of this Certificate. You must meet the Catastrophic Threshold for Catastrophic Services during each calendar year before We provide Catastrophic Coverage. The individual Catastrophic Threshold applies to each person covered under this Certificate. If You have other than individual coverage, after the Catastrophic Threshold for You and Your covered family members collectively totals the family Catastrophic Threshold amount in a calendar Year, the Catastrophic Threshold is deemed to be met for the rest of that calendar year for all covered family members.

C. Catastrophic Allowed Amount.

"Catastrophic Allowed Amount" means the maximum combined amount We will pay for the Catastrophic Services covered under this Certificate, before any applicable Catastrophic Threshold amounts are subtracted. We determine Our Catastrophic Allowed Amount based on the EmblemHealth City of New York Catastrophic Schedule of Allowances.

The Catastrophic Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Catastrophic Allowed Amount. You must pay the difference between Our payment(s) and the Non-Participating Provider's charge. This difference may be substantial, even after Catastrophic Benefit payments. Contact Us at the number on Your ID card or visit Our website at www.emblemhealth.com for information about Your financial responsibility when You receive Catastrophic Services.

D. Catastrophic Benefits.

Each calendar year, Your Catastrophic Benefits are determined according to the formula set forth below:

Catastrophic Allowed Amount for Catastrophic Services
MINUS
EmblemHealth Payments for Catastrophic Services
MINUS
Catastrophic Threshold
EQUALS
Catastrophic Benefit Payment

E. Your Additional Payments for Catastrophic Services.

When You receive Catastrophic Services from a Non-Participating Provider, You must pay any difference between Our combined payment(s) for Catastrophic Services and the Non-Participating Provider's actual charge. This difference may be substantial.

F. Filing a Claim for Catastrophic Benefits.

We will automatically determine if Catastrophic Coverage applies when We process Your claim(s) for services of Non-Participating Providers. You or Your Non-Participating Provider must file a claim with Us for out-of-network services, but You or the Provider do not need to file a separate claim to request Catastrophic Coverage.

SECTION XV

COVERAGE FOR MEDICARE ELIGIBLE INDIVIDUALS

1. GENERAL

A. Medicare Eligible Members.

If You or any of Your covered dependents are eligible for Medicare, you must enroll in Medicare (both Part A and Part B) to avoid a reduction of Your benefits under this Certificate.

If You are Medicare eligible by reason of age, You will receive only those benefits listed in this section. If You or any of Your covered dependents are eligible for Medicare and fail to enroll in Medicare (both Part A and Part B), We will reduce Your benefits. Your benefits will be determined according to this section as if You had enrolled in Medicare (both Part A and Part B) and received Medicare benefits. This means that Your reimbursement will be significantly reduced.

If You are an active employee or the spouse of an active employee, then the special rules set forth in paragraph B below apply to You.

If You are eligible for Medicare by reason of disability, then Medicare is Your primary plan. This Certificate is Your secondary plan and We will coordinate Your benefits with those provided by Medicare.

If You are not eligible for Medicare, then this section does not apply to You.

B. Special Rules for Active Employees. If You are an active employee, this section does not apply to You and Your covered dependents. If You are an active employee, regardless of Your age, coverage for You and Your covered dependents is provided under this Certificate as Your primary plan for the Covered Services listed in this Certificate as well as any Optional Rider benefits that you have elected. Medicare is Your secondary plan if You choose to enroll in Medicare. Your reimbursement will not be reduced if You choose not to enroll in Medicare while You are an active employee.

See paragraph C of this section for special rules if You have end stage renal disease.

C. Special Provisions for Those with End Stage Renal Disease. If You are disabled due to end-stage renal disease making You eligible for Medicare, Your benefits for Covered Services incurred due to that condition will be administered as set forth in this paragraph.

(a) During the first thirty (30) months during which You incur Covered Services for renal disease, Your benefits will be determined as follows:
  (i) This Certificate will be the primary plan, subject to the terms set forth in the Coordination of Benefits section of this Certificate;
  (ii) Medicare will be the secondary plan.

(b) After the first thirty (30) months during which You incur Covered Services for renal disease, Your benefits will be determined as follows:
  (i) Medicare will be the primary plan and will pay benefits available under Medicare;
  (iii) This Certificate will be a secondary plan, subject to the terms set forth in the Coordination of Benefits section of this Certificate. We will pay benefits only to the extent that benefits are not paid by Medicare and in accordance with the terms of this section.

2. Benefits and Limitations.

A. Covered Services.

We will pay benefits that supplement payments made to You or on Your behalf by Medicare for the services described below. We do not cover the Medicare Part B (medical) deductible. After You meet the Part B deductible, Medicare will generally pay eighty percent (80%) of Your covered service. After You meet an additional $50 Deductible under this Certificate, We will pay the twenty percent (20%) balance, less

any applicable Copayment. In certain instances, by operation of law, Medicare may reduce its payment below eighty percent (80%) of the Medicare reasonable charge. If this occurs, We will continue to pay You for twenty percent (20%) of the Medicare reasonable charge, less any applicable Copayment. Any charges in excess of the amount set by Medicare are not covered. You are responsible to pay such charges in addition to any applicable Deductible and Copayments. The Out-of-Pocket Limit that applies to this Certificate does not apply to benefits provided under this paragraph.

You must file a claim for your Medicare benefits before filing a claim with Us. When You file a claim with Us, please attach a copy of the Explanation of Medicare Benefits form to Your claim form. If You receive services from a Provider that accepts Medicare assignment or who is a Preferred or Participating Provider with Us, We will reimburse the Provider directly.

After you meet the Medicare and plan Deductibles, the services set forth below are covered, subject to the Copayment shown. The service must have been covered by Medicare to be eligible for benefits under this section.

- Primary Care Physician Office Visits: $15 Copayment per visit
- Specialist Office Visit: $15 Copayment per visit
- Allergy testing/injections: $15 Copayment per visit
- X-rays: $15 Copayment per visit
- Laboratory tests: $15 Copayment per test
- Complex diagnostic and radiology services: $15 Copayment per visit
- Radiation therapy: $15 Copayment per visit
- Urgent Care Services: $15 Copayment per visit
- Emergency Care (Professional Component): $15 Copayment per visit
- Mental Health Care (Outpatient): $15 Copayment per visit
- Substance Use Disorder Services (Outpatient): $15 Copayment per visit
- Physical, Occupational, and Speech Therapy: $15 Copayment per visit
- Cardiac Rehabilitation: $15 Copayment per visit
- Pulmonary Rehabilitation: $15 Copayment per visit
- Chiropractic Care: $15 Copayment per visit
- Podiatry Care: $15 Copayment per visit
- Vision Care: $15 Copayment per visit

- Ambulance: Subject to a $25 Deductible per family and a $2,500 Annual Maximum per person. Deductible and Annual Maximum are combined with durable medical equipment and private duty nursing. See Additional Covered Services paragraph below.

- Durable Medical Equipment: Subject to a $25 Deductible per family and a $2,500 Annual Maximum per person. Deductible and Annual Maximum are

combined with ambulance and private duty nursing. See Additional Covered Services paragraph below.

We do not provide coverage in those instances where Medicare denies coverage, except for the listed services when rendered outside of the United States.

We will not duplicate payments made by Medicare for any of these services.

B. Additional Covered Services.

We will cover the additional services listed below if Medicare does not provide coverage. After You meet a $25 Deductible per family, We will pay the amount set forth below. You are responsible to pay any balance.

- Private Duty Nursing: We pay 80% of the negotiated rate or billed charge.
- Durable Medical Equipment: We pay 80% of the negotiated rate or billed charge.
- Ambulance: We pay 80% of the negotiated rate or billed charge.

We will pay up to $2,500 per person in each calendar year for these services and emergency ambulance combined. After You meet this annual maximum, you are responsible to pay for all private duty nursing services and durable medical equipment, as well as for any ambulance costs not reimbursed by Medicare for the rest of the calendar year.

We will not duplicate payments made by Medicare for any of these services. The Out-of-Pocket Limit that applies to this Certificate does not apply to benefits provided under this paragraph.

C. When Medicare Benefits Are Not Available.
Medicare does not cover services rendered outside of the United States. We will provide benefits under this Certificate for Covered Services rendered to You outside of the United States as if You are not eligible for Medicare.

D. Standards of Coverage, Limitations and Exclusions.
Except as specifically provided otherwise, the standards of coverage, limitations and exclusions set forth in this Certificate apply to all benefits payable under this section.

SECTION XVI

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. 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.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or 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.

C. Conversion Therapy.
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under eighteen (18) years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, 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 Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., 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 the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

E. 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, Pre-Hospital Emergency Medical Services and ambulance services otherwise covered under this Certificate to treat Your Emergency Condition.

F. Dental Services.
We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within twelve (12) months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Certificate.

G. 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 as described in the Outpatient and Professional Services section of this Certificate, 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 this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

H. 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 or for services as a result of Your medical condition (including both physical and mental health conditions).

I. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. 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.

K. Medically Necessary.
In general, We will not Cover any health care service, procedure, treatment, test, 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 service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

L. 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). When You are enrolled in Medicare, We will reduce Our benefits by the amount Medicare pays for Covered Services. Except as otherwise required by law, if You are a Medicare-eligible retiree, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not enrolled in premium-free Medicare.

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

N. 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.

O. Services Not Listed.
We do not Cover services that are not listed in this Certificate as being Covered.

P. Services Provided by a Family Member.
We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

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

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

S. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses.

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

U. 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.

SECTION XVII

Claim Determinations

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. 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. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. 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 www.emblemhealth.com. Completed claim forms should be sent to the address on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Certificate or visiting Our website at www.emblemhealth.com.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within one hundred eighty (180) days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the one hundred eighty (180) day period, You must submit it as soon as reasonably possible. In no event, except in the absence of legal capacity, may a claim be filed more than one (1) year from the time the claim was required to be filed.

D. 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 New York Public Health Law Section 238-a(1).

E. 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 contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance

Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within fifteen (15) days from receipt of the claim.

   If We need additional information, We will request it within fifteen (15) days from receipt of the claim. You will have forty-five (45) calendar days to submit the information. If We receive the information within forty-five (45) days, We will make a determination and provide notice to You (or Your designee) in writing, within fifteen (15) days of Our receipt of the information. If all necessary information is not received within forty-five (45) days, We will make a determination within fifteen (15) calendar days of the end of the forty-five (45)-day period.

2. **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 seventy-two (72) hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within twenty-four (24) hours. You will then have forty-eight (48) hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within forty-eight (48) hours of the earlier of Our receipt of the information or the end of the forty-eight (48)-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. 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 thirty (30) calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within thirty (30) calendar days. You will then have forty-five (45) calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within fifteen (15) calendar days of the earlier of Our receipt of the information or the end of the forty-five (45)-day period if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within

thirty (30) days of receipt of the claim (when submitted through the internet or e-mail) and forty-five (45) days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within fifteen (15) days of Our determination that payment is due but no later than thirty (30) days (for claims submitted through the internet or e-mail) or forty-five (45) days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION XVIII

Grievance Procedures

A. 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.

B. Filing a Grievance.
You can contact Us by phone at the number on Your ID card, in person, or in writing to file a Grievance. 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 one hundred eighty (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 fifteen (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 will 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.

You may ask that We send You electronic notification of a Grievance or Grievance Appeal determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit Our website at www.emblemhealth.com. You can opt out of electronic notifications at any time.

C. 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 forty-eight (48) hours of receipt of all necessary information or seventy-two (72) hours of receipt of Your Grievance. Written notice will be provided within seventy-two (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 fifteen (15) calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within thirty (30) calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within forty-five (45) calendar days of receipt of all necessary information.

D. Grievance Appeals.
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card, in person, or in writing. You have up to sixty (60) business days from receipt of the Grievance determination to file an Appeal.

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

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or seventy-two (72) hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that	Fifteen (15) calendar days of receipt of Your Appeal.

has not yet been provided.)

Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	Thirty (30) calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	Thirty (30) business days of receipt of all necessary information to make a determination.

E. Assistance.
If You remain dissatisfied with Our Appeal 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
Website: 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
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XIX

Utilization Review

A. 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. 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. The toll-free telephone number is available at least forty (40) hours a

week with an after-hours answering machine.

Initial determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) for mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. Appeal determinations that services are not Medically Necessary will be made by: 1) licensed Physicians who are board certified or board eligible in the same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review ; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) for mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary.

We have developed guidelines and protocols to assist Us in this process. We will use evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website at www.emblemhealth.com.

You may ask that We send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit Our website at www.emblemhealth.com. You can opt out of electronic notifications at any time.

B. Preauthorization Reviews.

1. **Non-Urgent 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 (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have forty-five (45) calendar days to submit the information. If We receive the requested information within forty-five (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 (3) business days of Our receipt of the information. If all necessary information is not received within forty-five (45) days, We will make a determination within fifteen (15) calendar days of the earlier of the receipt of part of the requested information or the end of the forty-five (45) day period.

2. **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 seventy-two (72) hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within twenty-four (24) hours. You or Your Provider will then have forty-eight (48) hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within forty-eight (48) hours of the earlier of Our receipt of the information or the end of the forty-eight (48)-hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within seventy-two (72) hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

4. **Inpatient Rehabilitation Services Reviews.** After receiving a Preauthorization request for coverage of inpatient rehabilitation services following an inpatient Hospital admission provided by a Hospital or skilled nursing facility, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information.

5. **Crisis Stabilization Centers.** Coverage for services provided at participating crisis stabilization centers licensed under New York Mental Hygiene Law section 36.01 and in other states, those which are accredited by the joint commission as alcoholism or chemical dependence substance use treatment programs and are similarly licensed, certified or otherwise authorized in the state where the Facility is located, are not subject to Preauthorization. We may review the treatment provided by crisis stabilization centers retrospectively to determine whether it

was Medically Necessary and We will use clinical review tools designated by OASAS or approved by OMH. If any treatment by a participating crisis stabilization center is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your treatment.

6. **Preauthorization for Rabies Treatment.** Post-exposure rabies treatment authorized by a county health authority is sufficient to be considered Preauthorized by Us.

C. Concurrent Reviews.

1. **Non-Urgent 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 (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have forty-five (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 (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of fifteen (15) calendar days of the receipt of part of the requested information or fifteen (15) calendar days of the end of the forty-five (45)-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least twenty-four (24) hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within twenty-four (24) hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least twenty-four (24) hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of seventy-two (72) hours or one (1) business day of receipt of the request. If We need additional information, We will request it within twenty-four (24) hours. You or Your Provider will then have forty-eight (48) hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or forty-eight (48) hours of Our receipt of the information or, if We do not receive the information, within forty-eight (48) hours of the end of the forty-eight (48)-hour period.

3. **Home Health Care Reviews.** 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 (1) 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 seventy-two (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.

4. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least twenty-four (24) hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within twenty-four (24) hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

5. **Inpatient Mental Health Treatment at Participating Hospitals or Participating Crisis Residence Facilities Licensed or Operated by the Office of Mental Health (OMH).** Inpatient mental health treatment at a participating Hospital as defined in New York Mental Hygiene Law Section 1.03(10) or sub-acute mental health treatment at a participating crisis residence Facility that is licensed or operated by OMH is not subject to Preauthorization.

   If You are under 18 years of age, coverage is not subject to concurrent review for the first 14 days of the admission if the Hospital or Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission, performs daily clinical review, and participates in periodic consultation with Us to ensure that the Hospital or Facility is using the OMH-approved evidence-based and peer reviewed clinical review criteria utilized by Us and appropriate to Your age.

   If You are 18 years of age or older, coverage is not subject to concurrent review during the first 30 days of the admission if the Hospital or Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission, performs daily clinical review, and participates in periodic consultation with Us to ensure that the Hospital or Facility is using the OMH-approved evidence-based and peer reviewed clinical review criteria utilized by Us and appropriate to Your age. However, We may perform concurrent review during the first 30 days if You meet clinical criteria designated by OMH or where You are admitted to a Hospital or Facility which has been designated by OMH for concurrent review.

   Regardless of Your age, We may review the entire stay to determine whether it was Medically Necessary. If any portion of the stay is denied as not Medically

Necessary, You are only responsible for the In-Network Cost-Sharing that would otherwise apply to Your admission.

6. **Inpatient Substance Use Disorder Treatment at Participating Facilities Licensed, Certified or Otherwise Authorized by OASAS.** Inpatient substance use disorder treatment at a participating Facility that is licensed, certified or otherwise authorized by OASAS is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first twenty-eight (28) days of the inpatient admission if the Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first twenty-eight (28) days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

7. **Outpatient Substance Use Disorder Treatment at Participating Facilities Licensed, Certified or Otherwise Authorized by OASAS.** Outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating Facility that is licensed, certified or otherwise authorized by OASAS is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed twenty-eight (28) visits, if the Facility notifies Us of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed twenty-eight (28) visits, We may review the entire outpatient treatment to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your outpatient treatment.

D. 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 thirty (30) calendar days of the receipt of the request. If We need additional information, We will request it within thirty (30) calendar days. You or Your Provider will then have forty-five (45) calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within fifteen (15) calendar days of the earlier of Our receipt of all or part of the requested information or the end of the forty-five (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.

E. 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.

F. Step Therapy Override Determinations.
You, Your designee, or Your Health Care Professional may request a step therapy protocol override determination for coverage of a Prescription Drug selected by Your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for You and Your medical condition.

1. **Supporting Rationale and Documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a Health Care Professional, demonstrating that:
   - The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to You;
   - The required Prescription Drug(s) is expected to be ineffective based on Your known clinical history, condition, and Prescription Drug regimen;
   - You have tried the required Prescription Drug(s) while covered by Us or under Your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
   - You are stable on a Prescription Drug(s) selected by Your Health Care Professional for Your medical condition, provided this does not prevent Us from requiring You to try an AB-rated generic equivalent; or
   - The required Prescription Drug(s) is not in Your best interest because it will likely cause a significant barrier to Your adherence to or compliance with Your plan of care, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. **Standard Review.** We will make a step therapy protocol override determination and provide notification to You (or Your designee) and where appropriate, Your

Health Care Professional, within seventy-two (72) hours of receipt of the supporting rationale and documentation.

3. **Expedited Review.** If You have a medical condition that places Your health in serious jeopardy without the Prescription Drug prescribed by Your Health Care Professional, We will make a step therapy protocol override determination and provide notification to You (or Your designee) and Your Health Care Professional within twenty-four (24) hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, We will request the information within seventy-two (72) hours for Preauthorization and retrospective reviews, the lesser of seventy-two (72) hours or one (1) business day for concurrent reviews, and twenty-four (24) hours for expedited reviews. You or Your Health Care Professional will have forty-five (45) calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and forty-eight (48) hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of seventy-two (72) hours of Our receipt of the information or fifteen (15) calendar days of the end of the forty-five (45)-day period if the information is not received. For concurrent reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of seventy-two (72) hours or one (1) business day of Our receipt of the information or fifteen (15) calendar days of the end of the forty-five (45)-day period if the information is not received. For retrospective reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of seventy-two (72) hours of Our receipt of the information or fifteen (15) calendar days of the end of the forty-five (45)-day period if the information is not received. For expedited reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of twenty-four (24) hours of Our receipt of the information or forty-eight (48) hours of the end of the forty-eight (48)-hour period if the information is not received.

If We do not make a determination within seventy-two (72) hours (or twenty-four (24) hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

G. Reconsideration.

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination

or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

H. 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 have up to one hundred eighty (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 fifteen (15) calendar days of receipt. This acknowledgment will, if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** 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. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
    - A written 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 (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Authorization Denial.** You also have the right to Appeal the denial of a request for an authorization to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network authorization denial, You or Your designee must submit a written 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 Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
- Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

I. Standard Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within thirty (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 (2) business days after the determination is made, but no later than thirty (30) calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within thirty (30) calendar days of receipt of the information necessary to conduct the Appeal or sixty (60) days of receipt of the Appeal. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than sixty (60) calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review 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, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of seventy-two (72) hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within twenty-four (24) hours after the determination is made, but no later than seventy-two (72) hours after receipt of the Appeal request.

   If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

   Our failure to render a determination of Your Appeal within thirty (30) calendar

days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least twenty-four (24) hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within twenty-four (24) hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within twenty-four (24) hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

J. Full and Fair Review of an Appeal.
We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

K. Appeal Assistance.
If You need assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XX

External Appeal

A. Your Right to an External Appeal.
In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (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; or is an emergency

service or a surprise bill (including whether the correct Cost-Sharing was applied), 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 (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate; 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).

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.

If We have denied coverage on the basis that the service is not Medically Necessary You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph “A” above.

C. 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 (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph “A” above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure Covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) 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

2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. 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.

D. 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 (2) requirements for an external appeal in paragraph "A" 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 (2) 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.

E. Your Right to Appeal an Out-of-Network Authorization Denial to a Non-Participating Provider.
If We have denied coverage of a request for an authorization to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care 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.

F. Your Right to Appeal a Formulary Exception Denial.
If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this Certificate for more information on the formulary exception process.

G. The External Appeal Process.
You have four (4) 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 (4) 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 (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within thirty (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 (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) 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 seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must 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 Your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within seventy-two (72) hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

If Your internal formulary exception request received an expedited review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within twenty-four (24) hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within seventy-two (72) hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

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 Certificate. 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 cost 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 the research, or costs that would not be Covered under this Certificate for 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 twenty-five dollars ($25) for each external appeal, not to exceed seventy-five dollars ($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.

H. 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 (4) 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 XXI

Coordination of Benefits

This section applies when You also have group health coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. **"Plan"** is other group health coverage with which We will coordinate benefits. The term "plan" includes:
    - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

- Medical benefits coverage, in group and individual automobile “no-fault” and traditional liability “fault” type contracts.
- Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private insurance coverage.

3. **“Primary plan”** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. **“Secondary plan”** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.
The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents’ plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child’s health care expenses:
    - The plan of the parent who has custody will be primary;
    - If the parent with custody has remarried, and the child is also covered as a child under the step-parent’s plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and

- If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.
Except as described below, We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.

2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.

3. If We request information from a non-complying plan and do not receive it within thirty (30) days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

If a blanket accident insurance policy issued in accordance with Section 1015.11 of the General Business Law contains a provision that its benefits are excess or always secondary, then this Certificate is primary.

SECTION XXII

Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Group and/or Subscriber has failed to pay Premiums within thirty (30) days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.

2. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium had been paid.

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the end of the month in which the Child turns twenty-six (26) years of age.

6. For all other Dependents, the day on which the Dependent ceases to be eligible.

7. The end of the month following the Group's provision of written notice of termination of coverage to Us; or such later termination date requested by the Group's notice.

8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber and/or the Subscriber's Dependent, as applicable. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

9. If the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application, We will rescind coverage, after 30 days' prior written notice, if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate.

10. The date that the Group Contract is terminated. If We decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least ninety (90) days' prior written notice.

11. If We decide to stop offering all hospital, surgical and medical expense coverage in the large group market in this state, We will provide written notice to the Group and Subscriber at least one hundred eighty (180) days prior to when the coverage will cease.

12. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

13. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least thirty (30) days prior to when the coverage will cease.

14. The date there is no longer any Subscriber who lives, resides, or works in Our Service Area.

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

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage. See the Conversion Right to a New Contract after Termination section of this Certificate for Your right to conversion to an individual Contract.

SECTION XXIII

Extension of Benefits

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Group Contract terminates, or on the date Your coverage under this Certificate 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.

A. When You May Continue Benefits.

When Your coverage under this Certificate ends, We will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within thirty-one (31) days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to twelve (12) months from the date Your coverage ends for Covered Services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

B. Termination of Extension of Benefits.

Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- Twelve (12) months from the date extended benefits began (if Your benefits are extended based on termination of employment); or
- With respect to the twelve (12) month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

C. Limits on Extended Benefits.

We will not pay extended benefits:

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

SECTION XXIV

Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

A. Qualifying Events.

Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Loss of covered Child status under the plan rules; or
    - Death of the Subscriber.

If You want to continue coverage, You must request continuation from the Group in writing and make the first Premium payment within the sixty (60)-day period following

the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to one hundred and two percent (102%) of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

1. The date thirty-six (36) months after the Subscriber's coverage would have terminated because of termination of employment;
2. If You are a covered Spouse or Child, the date thirty-six (36) months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See the Conversion Right to a New Contract after Termination section of this Certificate.

B. Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty.

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 continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. 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
2. You serve no more than four (4) years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within sixty (60) days of being ordered to active duty and You pay the Group the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent

under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Certificate may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.
2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within thirty-one (31) days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

C. Availability of Age 29 Dependent Coverage Extension – Young Adult Option.
The Subscriber's Child may be eligible to purchase continuation coverage under the Group's Contract through the age of twenty-nine (29) if he or she:

1. Is under the age of thirty (30);
2. Is not married;
3. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
4. Lives, works or resides in New York State or Our Service Area; and
5. Is not covered by Medicare.

The Child may purchase continuation coverage even if he or she is not financially dependent on his or her parent(s) and does not need to live with his or her parent(s).

The Subscriber's Child may elect this coverage:

1. Within sixty (60) days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within sixty (60) days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within thirty (30) days of when the Group or the Group's designee receives notice and We receive Premium payment; or
3. During an annual thirty (30)-day open enrollment period, in which case coverage will be prospective and will start within thirty (30) days of when the Group or the Group's designee receives notice of election and We receive Premium payment.

The Subscriber or Subscriber's Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Certificate. The Child's children are not eligible for coverage under this option.

SECTION XXV

Conversion Right to a New Contract after Termination

A. Circumstances Giving Rise to Right to Conversion.
You have the right to convert to a new Contract if coverage under this Certificate terminates under the circumstances described below.

1. **Termination of the Group Contract.** If the Group Contract between Us and the Group is terminated as set forth in the Termination of Coverage section of this Certificate, and the Group has not replaced the coverage with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Contract as a direct payment member.

2. **If You Are No Longer Covered in a Group.** If Your coverage terminates under the Termination of Coverage section of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Contract as a direct payment member.

3. **On the Death of the Subscriber.** If coverage terminates under the Termination of Coverage section of this Certificate because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

4. **Termination of Your Marriage.** If a Spouse's coverage terminates under the Termination of Coverage section of this Certificate 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.

5. **Termination of Coverage of a Child.** If a Child's coverage terminates under the Termination of Coverage section of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.

6. **Termination of Your Temporary Continuation of Coverage.** If coverage terminates under the Termination of Coverage section of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Contract as a direct payment member.

7. **Termination of Your Young Adult Coverage.** If a Child's young adult coverage terminates under the Termination of Coverage section of this Certificate, the

Child is entitled to purchase a new Contract as a direct payment member.

B. 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 sixty (60) days after termination of coverage under this Certificate. You must also pay the first Premium of the new Contract at the time You apply for coverage.

C. 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 (4) Contracts offered by Us or Our affiliated HMO, Health Insurance Plan of Greater New York, an EmblemHealth company. The coverage may not be the same as Your current coverage. If You are age sixty-five (65) or over and enrolled in Medicare, We will also offer You contracts issued to Medicare-enrolled individuals.

SECTION XXVI

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 Certificate 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 under this Certificate or legal claims based on a denial of benefits or request for plan documents to any person, corporation or other organization and any such assignment will be void and unenforceable. You cannot assign any monies due under this Certificate to any person, corporation or other organization unless it is an assignment to Your Non-Participating Provider licensed under New York Public Health Law Article 30 for services described in the Ambulance and Pre-Hospital Emergency Medical Services Section of this Certificate.

Assignment means the transfer to another person, corporation or other organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services or Your right to sue based on a denial of benefits or request for plan documents. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. Changes in this Certificate.
We may unilaterally change this Certificate upon renewal, if We give the Group sixty (60) days' prior written notice.

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

5. Clerical Error.
Clerical error, whether by the Group or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, 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. Conformity with Law.
Any term of this Certificate which conflicts with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.
Some of the benefits in this Certificate 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.

8. Enrollment.
The Group will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Group Members covered under this Certificate, and any other information required to confirm their eligibility for coverage.

The Group will provide Us with this information upon request.

The Group will provide Us with the enrollment form including Your name, address, age, and social security number and advise Us in writing when You are to be added to or subtracted from Our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date of the Group's Contract with Us. If the Group fails to so advise Us, the Group will be responsible for the cost of any claims paid by Us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of forty-five (45) days.

9. Entire Agreement.
This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

10. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

11. Furnishing Information and Audit.
The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons such as 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. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group's New York office.

12. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

13. Incontestability.
No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

14. 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.

15. Input in Developing Our Policies.
Subscribers may participate in the development of Our policies by writing to Us with Your suggestions. As an Article 43, New York State not-for-profit health services corporation, EmblemHealth Plan, Inc., the EmblemHealth company that underwrites this Certificate, is required by the New York Insurance Law to have a board of directors whose members are representative of EmblemHealth's Network Hospitals or medical professionals, members, and the general public.

16. Material Accessibility.
We will give the Group, and the Group will give You ID cards, Certificates, riders and other necessary materials.

17. More Information about Your Health Plan.
You can request additional information about Your coverage under this Certificate. 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 Certificate.
- A written description of Our quality assurance program.
- A copy of Our medical policy 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 e.g., Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Certificate.

18. Notice.
Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery or to the address of the Group. If notice is delivered to You electronically, You may also request a copy of the notice from Us. 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: the address on Your ID card.

19. Premium Refund.
We will give any refund of Premiums, if due, to the Group.

20. Recovery of Overpayments.
On occasion, a payment may 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 sixty (60) days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than twenty-four (24) months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

21. Renewal Date.
The renewal date for this Certificate is the anniversary of the effective date of the Group Contract of each year. This Certificate will automatically renew each year on the renewal date, unless otherwise terminated by Us or the Group as permitted by this Certificate.

22. Right to Develop Guidelines and Administrative Rules.
We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards 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 Certificate.

23. 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 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.

24. Severability.
The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.

25. Significant Change in Circumstances.
If We are unable to arrange for Covered Services as provided under this Certificate 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.

26. 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 Certificate. 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 Section 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 shall be deemed that You did not take any action against Our rights or violate any contract between You and Us. The law conclusively presumes that the settlement between You and the responsible party does not include any compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within thirty (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.

27. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this Certificate and nothing in this Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

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

29. Translation Services.
Translation services are available free of charge under this Certificate for non-English speaking Members. Please contact Us at the number on Your ID card to access these services.

30. Venue for Legal Action.
If a dispute arises under this Certificate, 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 New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

31. Waiver.
The waiver by any party of any breach of any provision of this Certificate 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.

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

33. Who Receives Payment under this Certificate.
Payments under this Certificate 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 the Subscriber or the Provider. However, We will directly pay a Provider instead of You for covered Emergency Services and surprise bills. For pre-hospital emergency medical services, emergency ground and water ambulance transportation with dates of service on and after January 1, 2025, if You assign benefits to a Non-Participating Provider licensed under New York Public Health Law Article 30, We will pay the Non-Participating Provider directly. If You do not assign benefits to a Non-Participating Provider licensed under New York Public Health Law Article 30, We will pay You and the Non-Participating Provider jointly.

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

35. Your Medical Records and Reports.
In order to provide Your coverage under this Certificate, 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 Certificate, except as prohibited by state or federal law, 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, to the extent permitted under state or federal law, 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 Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

36. Your Rights and Responsibilities.
As a Member, You have rights and responsibilities when receiving health care. As Your health care partner, We want to make sure Your rights are respected while providing Your health benefits. You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

You have the right to access Our Participating Providers.

As a Member, You should also take an active role in Your care. We encourage You to:
- Understand Your health problems as well as You can and work with Your Providers to make a treatment plan that You all agree on;
- Follow the treatment plan that You have agreed on with Your doctors or Providers;
- Give Us, Your doctors and other Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your Certificate. This may include information about other health insurance benefits You have along with Your coverage with Us; and

- Inform Us if You have any changes to Your name, address or Dependents covered under Your Certificate.

SECTION XXVII

SCHEDULE OF BENEFITS
City of New York

You should always consider receiving health services through Preferred Providers in Our CBP network when available. Preferred Providers may not be available for all Covered Services. Not all Participating Providers are Preferred Providers.

COST-SHARING	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Deductible • Individual • Family	None None	None None	$200 $500	
Out-of-Pocket Limit • Individual • Family Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.	$4,550 $9,100 Combined with Participating	$4,550 $9,100 Combined with Preferred	None None We will pay the Allowed Amount for Covered Non-Participating Provider services. The Allowed Amount is the GHI CBP Non-Participating Provider Schedule of Allowances amount. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of	

			how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that exceed the Allowed Amount do not apply towards the Deductible. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount. This excess amount may be substantial.	
Catastrophic Coverage for Certain Non-Participating Provider Services	Not Applicable.	Not Applicable.	$1,500 per person Catastrophic Threshold	See benefit for description.
OFFICE VISITS	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$0 Copayment	$15 Copayment	0% Coinsurance after Deductible	See benefit for description.
Specialist Office Visits (or Home Visits)	$0 Copayment	$30 Copayment	0% Coinsurance after Deductible	See benefit for description.

PREVENTIVE CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Well Child Visits and Immunizations*	Covered in full	Covered in full	0% Coinsurance after Deductible	See benefit for description.
• Adult Annual Physical Examinations*	Covered in full	Covered in full	0% Coinsurance after Deductible	
• Adult Immunizations*	Covered in full	Covered in full	0% Coinsurance after Deductible	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	0% Coinsurance after Deductible	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	Covered in full	0% Coinsurance after Deductible	
• Sterilization Procedures for Women*	Covered in full	Covered in full	0% Coinsurance after Deductible	
• Vasectomy	$0 Copayment	$0 Copayment	0% Coinsurance after Deductible	
• Bone Density Testing*	Covered in full	Covered in full	0% Coinsurance after Deductible	

• Screening for Prostate Cancer	Covered in full	Covered in full	0% Coinsurance after Deductible	
• Colon Cancer Screening*	Covered in full	Covered in full	0% Coinsurance after Deductible	
• All other preventive services required by USPSTF and HRSA	Covered in full	Covered in full	0% Coinsurance after Deductible	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	0% Coinsurance	0% Coinsurance	0% Coinsurance Not subject to Deductible.	See benefit for description.
Urgent Care Center	$50 Copayment	$100 Copayment	0% Coinsurance after Deductible	See benefit for description.

PROFESSIONAL SERVICES and CERTAIN OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting **Preauthorization required for MRI, MRA, PET scan, CAT scan, Nuclear Cardiology.**	$50 Copayment	$100 Copayment	0% Coinsurance after Deductible	See benefit for description.
Allergy Testing and Treatment • Testing • Treatment Performed in a PCP Office • Treatment Performed in a Specialist Office **Preauthorization Required after the 30th visit in a calendar year.**	$0 Copayment $0 Copayment $0 Copayment	$20 Copayment $15 Copayment $30 Copayment	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See benefit for description.
Anesthesia Services (all settings)	Covered in full	Covered in full	0% Coinsurance after Deductible	See benefit for description.

Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office **Preauthorization required.**	$0 Copayment	$30 Copayment	0% Coinsurance after Deductible	See benefit for description.
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	Covered in Full Covered in Full Covered in Full, after exhaustion of Hospital Plan benefit	Covered in Full Covered in Full Covered in Full, after exhaustion of Hospital Plan benefit	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible, after exhaustion of Hospital Plan benefit	See benefit for description.
Radiation Therapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required for Outpatient Radiation Therapy.**	Covered in Full Covered in Full Covered in Full	Covered in Full Covered in Full Covered in Full	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See benefit for description.
Chiropractic Services	$0 Copayment	$15 Copayment	0% Coinsurance after Deductible	See benefit for description.

Clinical Trials **Preauthorization required.**	Use Cost-Sharing for appropriate service if covered.	Use Cost-Sharing for appropriate service if covered.	Use Cost-Sharing for appropriate service if covered.	See benefit for description.
Diagnostic Testing • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	 $0 Copayment $0 Copayment $0 Copayment	 $20 Copayment $20 Copayment $20 Copayment	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See benefit for description.
Habilitation Services • Physical Therapy • Speech Therapy • Performed in a PCP Office • Performed in a Specialist Office **Preauthorization required for visits in excess of 16 visits per calendar year.**	 $0 Copayment $0 Copayment $0 Copayment	 $20 Copayment $15 Copayment $30 Copayment	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See benefit for description.
Home Health Care **Preauthorization required.**	$0 Copayment	$0 Copayment	$50 Copayment per Episode of Care	See benefit for description. 200 Visits per Plan Year by

				Preferred or Participating Providers. 40 visits per Plan Year by Non-Participating Providers. One (1) home health care visit is Covered at no Cost-Sharing following routine inpatient delivery if mother is discharged from the Hospital early.
Infertility Services **Preauthorization required.**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description.
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services (Not covered if medication is billed by the	 $0 Copayment $0 Copayment $0 Copayment	 $0 Copayment $0 Copayment $0 Copayment	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See benefit for description.

Hospital) **Preauthorization Required.** • Home Infusion Therapy **Preauthorization required.**	$0 Copayment	$0 Copayment	Use Cost-Sharing for appropriate service (Durable Medical Equipment, Private Duty Nursing, Prescription Drugs if Covered)	Home infusion does not count toward home health care visit limits.
Inpatient Medical Services (professional charge)	$0 Copayment	$0 Copayment	0% Coinsurance after Deductible	See benefit for description.
Interruption of Pregnancy	Covered in full	Covered in full	0% Coinsurance after Deductible	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	$0 Copayment $0 Copayment $0 Copayment	$20 Copayment $20 Copayment $20 Copayment	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See benefit for description.

Maternity and Newborn Care				See benefit for description.
• Prenatal Care • Prenatal Care provided in accordance with the comprehen-sive guidelines supported by USPSTF and HRSA	Covered in full	Covered in full	0% Coinsurance after Deductible	
• Prenatal Care that is not provided in accordance with the comprehen-sive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing	0% Coinsurance after Deductible	
• Physician and Midwife Services for Delivery	Covered in full	Covered in full	0% Coinsurance after Deductible	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pump	Covered in full	Covered in full	0% Coinsurance after Deductible	Covered for duration of breast feeding.
• Postnatal Care • Postnatal Care provided in accordance with the	Covered in full	Covered in full	0% Coinsurance after Deductible	

comprehensive guidelines supported by USPSTF and HRSA				
• Postnatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing	0% Coinsurance after Deductible	
Prescription Drugs Administered in Office or Outpatient Facilities				See benefit for description.
• Performed in a PCP Office	$0 Copayment	$0 Copayment	0% Coinsurance after Deductible	
• Performed in Specialist Office	$0 Copayment	$0 Copayment	0% Coinsurance after Deductible	
• Performed in Outpatient Facilities **Preauthorization required for certain specialty drugs.**	$0 Copayment	$0 Copayment	0% Coinsurance after Deductible	
Diagnostic Radiology Services				See benefit for description.
• Performed in a PCP Office	$0 Copayment	$20 Copayment	0% Coinsurance after Deductible	

• Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Preauthorization required for MRI, MRA, PET scan, CAT scan and Nuclear Cardiology.**	$0 Copayment $0 Copayment $0 Copayment	$20 Copayment $20 Copayment $20 Copayment	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility **Preauthorization required.** • Performed as Outpatient Hospital Services **Preauthorization required.**	 $0 Copayment $0 Copayment $0 Copayment	 $0 Copayment $0 Copayment $0 Copayment	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See benefit for description.

Rehabilitation • Physical Therapy • Speech Therapy • Performed in a PCP Office • Performed in a Specialist Office **Preauthorization required after 16 visits.**	$0 Copayment $0 Copayment $0 Copayment	$20 Copayment $15 Copayment $30 Copayment	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	See benefit for description. 16 visits per calendar year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$0 Copayment	$30 Copayment	0% Coinsurance after Deductible Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description.
Physician Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and				See benefit for description.

Corrective Surgery; and Transplants) • Inpatient Hospital Surgery (Physician Services Only) • Outpatient Hospital Surgery (Physician Services Only) • Surgery Performed at an Ambulatory Surgical Center (Physician Services Only) • Office Surgery **Preauthorization required unless performed in Office.**	$0 Copayment $0 Copayment $0 Copayment $0 Copayment	$0 Copayment $0 Copayment $0 Copayment $0 Copayment	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	
Telemedicine Program	$10 Copayment	$10 Copayment	Not Available	See benefit for description.
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment,	See the Certain Prescription Drug Cost-Sharing, but	See the Certain Prescription Drug Cost-Sharing, but	0% Coinsurance after Deductible	See benefit for description. See Certain Prescription Drugs benefit for

Supplies and Insulin (Up to a 90-day supply) • Diabetic Education	not more than $100 for a 30-day supply of insulin. $0 Copayment	not more than $100 for a 30-day supply of insulin. $15 Copayment	 0% Coinsurance after Deductible	description.
Durable Medical Equipment and Braces **Preauthorization required for items that cost $2,000 or more.** Nutritional Supplements and Enteral Formulas administered through a feeding tube **Preauthorization required for Nutritional Supplements and Enteral Formulas.**	Covered in full, after $100 Deductible for Preferred, Participating and Non-Participating Providers combined. 20% Coinsurance	Covered in full, after $100 Deductible for Preferred, Participating and Non-Participating Providers combined. 20% Coinsurance	0% Coinsurance, after $100 Deductible for Preferred, Participating and Non-Participating Providers combined. 20% Coinsurance	See benefit for description.
Medical Supplies **Preauthorization required for items that cost $2,000 or more.**	Covered in full, after $100 Deductible for Preferred, Participating and Non-Participating Providers combined.	Covered in full, after $100 Deductible for Preferred, Participating and Non-Participating Providers combined.	0% Coinsurance, after $100 Deductible for Preferred, Participating and Non-Participating Providers combined.	See benefit for description.

External Prosthetic Devices **Preauthorization required for items that cost $2,000 or more.**	Covered in full, after $100 Deductible for Preferred, Participating and Non-Participating Providers combined.	Covered in full, after $100 Deductible for Preferred, Participating and Non-Participating Providers combined.	0% Coinsurance, after $100 Deductible for Preferred, Participating and Non-Participating Providers combined.	See benefit for description.
Private Duty Nursing **Preauthorization required.**	$0 Copayment	$0 Copayment	20% Coinsurance after $250 Deductible	See benefit for description.
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care for a continuous confinement when in a Hospital or Residential Facility **Preauthorization required. Call Us or Our vendor at 1-800-692-2489. Preauthorization is not required for emergency admissions or for admissions at Participating Hospitals or crisis residence facilities licensed or operated by OMH.**	$300 Copayment up to a maximum of $750 per Plan Year. Maximum combined with Hospital Plan Copayment(s)	$300 Copayment up to a maximum of $750 per Plan Year. Maximum combined with Hospital Plan Copayment(s)	$500 Copayment up to a maximum of $1,250 per Plan Year. Maximum combined with Hospital Plan Copayment(s)	See benefit for description.
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient				See benefit for description.

Program Services) • Performed in an Office • Performed in a Facility	$0 Copayment Covered in full	$15 Copayment Covered in full	0% Coinsurance after Deductible 0% Coinsurance after Deductible	
ABA Treatment for Autism Spectrum Disorder	$0 Copayment	$15 Copayment	0% Coinsurance after Deductible	See benefit for description.
Assistive Communication Devices for Autism Spectrum Disorder	Covered in full	Covered in full	0% Coinsurance after Deductible	See benefit for description.
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization required. Preauthorization is not required for emergency admissions or for Participating Facilities licensed, certified or otherwise authorized by OASAS.**	$300 Copayment up to a maximum of $750 per Plan Year. Maximum combined with Hospital Plan Copayment(s).	$300 Copayment up to a maximum of $750 per Plan Year. Maximum combined with Hospital Plan Copayment(s).	$500 Copayment up to a maximum of $1,250 per Plan Year. Maximum combined with Hospital Plan Copayment(s).	See benefit for description.
Outpatient Substance Use Services • Office Visits	$0 Copayment	$15 Copayment	0% Coinsurance after Deductible	See benefit for description. Up to 20 visits per Plan Year may be used for family counseling.

• Opioid Treatment Programs	Covered in full	Covered in full	0% Coinsurance after Deductible	
• All Other Outpatient Services	Covered in full	Covered in full	0% Coinsurance after Deductible	

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Certificate, You will be responsible for the full cost of the services. You are responsible to request Preauthorization, if required, for services of Non-Participating Providers and You may be penalized if You fail to do so.

SECTION XXVIII

SCHEDULE OF BENEFITS FOR CERTAIN PRESCRIPTION DRUGS City of New York

CERTAIN PRESCRIPTION DRUGS			
Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy.			

SUBSTANCE USE DISORDER MEDICATIONS	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing
Retail Pharmacy			
30-day supply Tier 1 Tier 2 Tier 3 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	 $5 Co-payment or 20% Coinsurance, whichever is greater. $25 Co-payment or 40% Coinsurance, whichever is greater. $40 Co-payment or 50% Coinsurance, whichever is greater.	 $5 Co-payment or 20% Coinsurance, whichever is greater. $25 Co-payment or 40% Coinsurance, whichever is greater. $40 Co-payment or 50% Coinsurance, whichever is greater.	Non-Participating Provider services are not Covered and You pay the full cost.
Mail Order Pharmacy			
Up to a 90-day supply Tier 1	 $5 Co-payment or 20% Coinsurance, whichever is greater.	 $5 Co-payment or 20% Coinsurance, whichever is	Non-Participating Provider services are not Covered and You pay the full cost.

		greater.	
Tier 2	$25 Co-payment or 40% Coinsurance, whichever is greater.	$25 Co-payment or 40% Coinsurance, whichever is greater.	
Tier 3	$40 Co-payment or 50% Coinsurance, whichever is greater.	$40 Co-payment or 50% Coinsurance, whichever is greater.	
DIABETIC DRUGS, EQUIPMENT AND SUPPLIES; AND PRESCRIPTION DRUGS FOR IN VITRO FERTILIZATION AND FERTILITY PRESERVATION			
Retail Pharmacy			
30-day supply Tier 1	$5 Co-payment	$5 Co-payment	Non-Participating Provider services are not Covered and You pay the full cost.
Tier 2	$15 Co-payment	$15 Co-payment	
Mail Order Pharmacy			
Up to a 90-day supply Generic Drugs	$12.50 Co-payment	$12.50 Co-payment	Non-Participating Provider services are not Covered and You pay the full cost.
Brand Name Drugs	$37.50 Co-payment	$37.50 Co-payment	

CONTRACEPTIVE DRUGS, DEVICES AND PRODUCTS			
Retail Pharmacy			
Up to a 12-month supply Tier 1	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost.
Tier 2	Covered in full	Covered in full	
Tier 3	Covered in full	Covered in full	
Mail Order Pharmacy			
Up to a 12-month supply Tier 1	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost.
Tier 2	Covered in full	Covered in full	
Tier 3	Covered in full	Covered in full	

If a drug or prescription drug is not Covered under the Certificate, You will be responsible for the full cost of the drug.