THIS IS YOUR

HIP HMO PREFERRED HEALTH MAINTENANCE ORGANIZATION CERTIFICATE OF COVERAGE

Issued by

HEALTH INSURANCE PLAN OF GREATER NEW YORK (thereafter referred to as "HIP")
55 Water Street – New York, New York 10041

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between Health Insurance Plan of Greater New York (HIP) (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.

In-Network Benefits. This Certificate offers You the option to receive Covered Services on two 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 network. You should always consider receiving health services first through Our Preferred Providers.

2. **In-Network Benefits.** In-Network benefits are the lower level of coverage available. In-Network benefits apply when Your care is provided by Participating Providers that are not Preferred Providers in Our Network who are located within Our Service Area. You should always consider receiving health care services first through Preferred Providers and then from Participating Providers that are not Preferred Providers. In-Network care and In-Network preferred care Covered under this Certificate (including Hospitalization) must be provided, arranged or authorized in advance by Your Primary Care Physician and, when required, approved by Us. In order to receive In-Network benefits, You must contact Your Primary Care Physician before You obtain the services, except for services to treat an Emergency Condition described in the Emergency Services and Urgent Care section of this Certificate.

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.

Signed for HIP of Greater New York

Michael Palmateer

Michael Palmateer
Chief Executive Officer

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

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SECTION I

Definitions

Defined terms will appear capitalized throughout the 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.

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 is issued by HIP, 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 Coinsurance, Copayments, and/or Deductibles.

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 Coinsurance or Copayments are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific

Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Durable Medical Equipment ("DME"): 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 New York 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 Addiction Services and Supports, 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.

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 contractholder.

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

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; nurse practitioner; 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 Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

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

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (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.

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. The services of Non-Participating Providers are Covered only for Emergency Services or when authorized by Us.

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

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website 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.

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: The twelve (12)-month period beginning on the effective date of the Group Contract or any anniversary date thereafter, during which the Certificate is in effect

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this 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 nurse practitioner or Physician 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. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

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

Schedule of Benefits The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, Referral requirements, and other limits on Covered Services.

Service Area: The geographical area designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of: Bronx, Kings, Manhattan, Queens, Richmond, Rockland, Nassau, Suffolk, Westchester, Broome, Otsego, Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington, Delaware, Dutchess, Orange, Putnam, Sullivan and Ulster counties.

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.

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.

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

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

Us, We, Our: Health Insurance Plan of Greater New York (HIP) 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 HMO 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;
- 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.

When You are outside Our Service Area, coverage is limited to Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

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 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 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 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 has a gatekeeper, usually known as a Primary Care Physician ("PCP"). This Certificate requires that You select a Primary Care Physician ("PCP"). You need a written Referral from a PCP before receiving Specialist care from a Participating Provider. You may select any participating PCP who is available from the list of PCPs in the HMO Network. Each Member may select a different PCP. Children covered under this Certificate may designate a participating PCP who specializes in pediatric care. In certain circumstances, You may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this Certificate for more information about designating a Specialist. To select a PCP, visit Our website at www.emblemhealth.com. If You do not select a PCP, We will assign one to You.

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Certificate when the services provided are related to specialty care.

1. **Services Not Requiring a Referral from Your PCP.** Your PCP is responsible for determining the most appropriate treatment for Your health care needs. You do not need a Referral from Your PCP to a Participating Provider for the following services:
   - Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
   - Emergency Services;
   - Pre-Hospital Emergency Medical Services and emergency ambulance transportation;

- Maternal depression screening;
- Urgent Care;
- Chiropractic services;
- Outpatient mental health care;
- Outpatient substance use services;
- Diabetic eye exams from an ophthalmologist; and
- Refractive eye exams from an optometrist.

However, the Participating Provider must discuss the services and treatment plan with Your PCP; agree to follow Our policies and procedures including any procedures regarding Referrals or Preauthorization for services other than obstetric and gynecologic services rendered by such Participating Provider; and agree to provide services pursuant to a treatment plan (if any) approved by Us. See the Schedule of Benefits section of this Certificate for the services that require a Referral.

2. **Access to Providers and Changing Providers**. Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCP You selected, You should call the PCP 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 a HIP 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.

   You may change Your PCP by accessing Our website at www.emblemhealth.com, or by calling Customer Service. This can be done at any time through website access, or through Customer Service, Monday through Friday between 8 am and 8 pm and Saturday 8 am to 1 pm.

   You may change Your Specialist by contacting Your PCP to obtain a Referral. This can be done at any time during Your PCP's office hours.

   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 a Referral 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.

F. Services Subject To Preauthorization.

Our Preauthorization is required before You receive certain Covered Services. Your PCP is responsible for requesting Preauthorization for In-Network services.

G. Preauthorization/Notification Procedure.
If You seek coverage for services that require Preauthorization or notification Your Provider must call Us or Our vendor at the number on Your ID card.

Your Provider must contact Us to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or 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.
- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within forty-eight (48) hours after the actual delivery date if Your Hospital stay is expected to extend beyond forty-eight (48) hours for a vaginal birth or ninety-six (96) hours for cesarean birth.
- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

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

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

H. 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.

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

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;

- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- 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. For example, We will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

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

J. 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 Cost-Sharing. The Non-Participating Provider may only bill You for Your 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 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 thirty (30) days of receiving the dispute.

K. 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, including telephone or video using smart phones or other devices, by a Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

L. Case Management.

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and teamwork with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our case management program that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Certificate. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

M. Important Telephone Numbers and Addresses.

- CLAIMS
  Submit claim forms to this address:
  Medical Claims: P.O. Box 2845, New York, NY 10116-2845
  Hospital Claims: P.O. Box 2803, New York, NY 10116-2803

  Submit electronic claim forms to this email address:
  EmblemHealthClaimSubmission@emblemhealth.com

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  Members may call 833-269-4653

  Submit written Complaints and Grievances to this address:
  EmblemHealth Grievance and Appeals Department
  JAF Station
  P.O. Box 2844
  New York, NY 10016-2844

- SURPRISE BILL CERTIFICATION FORM
  Refer to the address on Your ID card
  Submit assignment of benefits forms for surprise bills to the address.

  MEDICAL EMERGENCIES AND URGENT CARE
  Members may call 833-269-4653
  Monday – Friday 8:00 a.m. – 8:00 p.m. and Saturday 8:00am – 1:00 p.m.

- MEMBER SERVICES
  833-269-4653
  (Member Services Representatives are available Monday – Friday, 8:00 a.m. – 8:00p.m. and Saturday 8:00 a.m. – 1:00 p.m.)

- PREAUTHORIZATION
  866-447-9717

- BEHAVIORAL HEALTH SERVICES
  Call the number on Your ID card

- OUR WEBSITE
  www.emblemhealth.com

SECTION III

Access to Care and Transitional Care

A. Referral to a Non-Participating Provider.
If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve a Referral to an appropriate Non-Participating Provider. Your Participating Provider must request prior approval of the Referral to a specific Non-Participating Provider. Approvals of Referrals 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 Referral, 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 paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing. In the event a Referral is not approved, any services rendered by a Non-Participating provider will not be Covered.

B. When a Specialist Can Be Your Primary Care Physician.
If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may ask that a Specialist who is a Participating Provider be Your PCP. We will consult with the Specialist and Your PCP and decide whether the Specialist should be Your PCP. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. We will not approve a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

C. Standing Referral to a Participating Specialist.
If You need ongoing specialty care, You may receive a "standing Referral" to a Specialist who is a Participating Provider. This means that You will not need a new Referral from Your PCP every time You need to see that Specialist. We will consult with the Specialist and Your PCP and decide whether You should have a "standing Referral." Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide your PCP with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing Referral to a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our Network. If We approve a standing Referral to a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

D. Specialty Care Center.
If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may request a Referral to a specialty care center with expertise in treating Your condition or disease. A specialty care center is a center that has an accreditation or designation from a state agency, the federal government or a national health organization as having special expertise to treat Your disease or condition. We will consult with Your PCP, Your Specialist, and the specialty care center to decide whether to approve such a Referral. Any Referral will be pursuant to a treatment plan developed by the specialty care center, and approved by Us in consultation Your PCP or Specialist and You. We will not approve a Referral to a non-participating specialty care center unless We determine that We do not have an appropriate specialty care center in Our Network. If We approve a Referral to a non-participating specialty care center, Covered Services rendered by the non-participating specialty care center pursuant to the approved treatment plan will be paid as if they were provided by a participating specialty care center. You will be responsible only for any applicable In-Network Cost-Sharing.

E. 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 ninety (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, Referrals, 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 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.

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

SECTION IV

Cost-Sharing Expenses and Allowed Amount

A. Deductible.

There is no Deductible for Covered Services under this Certificate during each Plan Year.

Equipment and Devices Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered Devices such as Durable Medical Equipment, External Hearing Aids. Cochlear Implants, External Prosthetic Devices, and/or shoe Inserts during each Plan Year before We provide coverage.

B. Copayments.

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

C. Out-of-Pocket Limit.

When You have met Your Out-of-Pocket Limit in payment of 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 Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit 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 that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family Out-of-Pocket Limit in payment of 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, out-of-network services approved by Us as an In-Network exception, and out-of-network dialysis, does not apply toward Your Out-of-Pocket Limit.

D. 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 Participating Providers will be the amount we have negotiated with the Participating Provider or the Participating Providers charge if less.

See the Emergency Services and Urgent Care section of this Certificate for the Allowed Amount

for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Certificate for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

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. You must live, work, or reside in Our Service Area to be 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. **Individual and Spouse.** If You selected Individual and Spouse coverage, then You and Your Spouse are covered.

3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.

4. **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 parent and child/children or 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 twenty-six (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 disability and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child qualifies 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 within thirty (30) days thereafter, coverage for Your Spouse and Child starts on the first day of the month following such marriage. 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 or Child.
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 towards 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 sixty (60) days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

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 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 833-269-4653 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 three hundred sixty-five (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 nineteen (19) and is not subject to Cost-Sharing 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 three hundred sixty-five (365) days have passed since the previous physical

examination visit. Vision screenings do not include refractions.

This benefit is not subject to Cost-Sharing 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 Cost-Sharing 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 screening for cervical cancer, laboratory and diagnostic services in connection with evaluating the screening for cervical tests. 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 Cost-Sharing 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 thirty-five (35) through thirty-nine (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 forty (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 Cost-Sharing 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, MRIs, and pathology evaluations to complete the screening process. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs, and pathology evaluations are not subject to Cost-Sharing when provided by a Preferred or Participating Provider.

F. Family Planning & 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 section 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, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Cost-Sharing when provided by a Participating Provider.

We also Cover vasectomies subject to Cost-Sharing.

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, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug section of this Certificate. Bone mineral density measurements or tests, drugs or devices 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 Cost-Sharing when provided by a 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. Prostate Cancer Screening. 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 fifty (50) and over who are asymptomatic and for men age forty (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 Cost-Sharing when provided by a Participating Provider.

I. Colon Cancer Screening. We Cover colon cancer screening for Members age forty-five (45) through seventy-five (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 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 or Referral 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 FAIR Health rate at the 80th percentile calculated using the place of pickup.

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 the 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 FAIR Health rate at the 80th percentile calculated using the place of pickup.

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 or the Non-Participating Provider's charge 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. Non-Emergency Ground Ambulance Transportation.

We Cover non-emergency ground ambulance transportation by a licensed ambulance service between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective acute care Facility; or
- From an Acute care Facility to a sub-acute setting.

C. Air Ambulance Services.

1. **Emergency Air Ambulance Services.** We Cover emergency air ambulance transportation worldwide by a licensed ambulance service to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency air ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

2. **Non-Emergency Air Ambulance Services.** We Cover non-emergency air ambulance transportation by a licensed ambulance service between Facilities when the transport is any of the following:
   - From a non-participating Hospital to a participating Hospital;
   - To a Hospital that provides a higher level of care that was not available at the original Hospital;
   - To a more cost-effective Acute care Facility; or
   - From an Acute care Facility to a sub-Acute setting.

3. **Payments for Air Ambulance Services.** We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the air ambulance service.

We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the air ambulance service or an amount We have determined is reasonable for the air ambulance. 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 air ambulance services is submitted to an independent dispute resolution entity (IDRE), We will pay the amount, if any, determined by the IDRE for the air ambulance services.

You are responsible for any Cost-Sharing for air ambulance services. The Non-Participating Provider may only bill You for Your Cost-Sharing. If You receive a bill from a Non-Participating Provider that is more than Your Cost-Sharing, You should contact Us.

D. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
    - The point of pick-up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

SECTION VIII

Emergency 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 or Referral requirements that apply to these benefits.

A. Emergency Services.
We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

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

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

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

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

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

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

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. If you are experiencing a mental health crisis, You may also call 988 for assistance. Emergency Department Care does not require Preauthorization. However, **only Emergency**

Services for the treatment of an Emergency Condition, are Covered in an emergency department. If You are uncertain whether a Hospital emergency department is the most appropriate place to receive care, You can call Us before You seek treatment.

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

2. **Emergency Hospital Admissions.** In the event You are **admitted** to the Hospital: You or someone on Your behalf must notify Us at the number listed in this Certificate and on Your ID card within forty-eight (48) hours of Your admission, or as soon as is reasonably possible.

   We Cover inpatient Hospital services following Emergency Department Care at a non-participating Hospital at the In-Network Cost-Sharing. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer.

B. Payments Relating to Emergency Services. We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the Emergency services.

We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the Emergency Service or an amount We have determined is reasonable for the Emergency 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 Emergency Services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for the services.

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

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

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to, or after Your visit.

2. **Out-of-Network.** We do not cover Urgent Care from a non-participating Urgent Care Center or Physician in Our Service Area.

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

SECTION IX

Outpatient and Professional 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 and Immunotherapy.
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 Covered under the Prescription Drug Coverage section of this Certificate.

We Cover scalp cooling systems used in connection with chemotherapy for cancer. A "scalp cooling system" means any device used to cool the human scalp to prevent or reduce hair loss during cancer chemotherapy treatment, provided such device is designed and intended for repeated use and is primarily and customarily used to serve a medical purpose.

E. Chiropractic Services.
We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any 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 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 Appeals 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 treatment; the costs of managing the research; or costs that would not be covered under this Certificate for or 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.

H. Dialysis.

We Cover dialysis treatments of an Acute or chronic kidney ailment.

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

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least thirty (30) days in advance of the proposed treatment date(s) and include the written order referred to above. The thirty (30)-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than ten (10) dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

I. Habilitation Services.

We Cover Habilitation Services consisting of physical therapy, speech therapy and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to ninety (90) visits, per-Plan Year. The visit limit applies to all habilitation and rehabilitation therapies combined.

J. 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 (RN);
- 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. Each visit by a member of the Home Health Agency is considered one (1) visit. 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.

K. 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 twelve (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 thirty-five (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 ultra sound;
   - Hysterosalpingogram;
   - Sono-hystogram;
   - Testis biopsy;

- Blood tests; and
- Medically appropriate treatment of ovulatory dysfunction.

Additional tests may be Covered if the tests are determined to be Medically Necessary.

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 ultra sound;
   - 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.

L. Infusion Therapy.
We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients 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.

M. 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 these 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 Participating Provider.

N. 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.

We Cover biomarker precision medical testing, including both single-analyte tests and multiplex panel tests, performed at a participating laboratory that is either CLIA certified or CLIA waived by the FDA, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring to guide treatment decisions for Your disease or condition when one or more of the following recognizes the efficacy and appropriateness of such testing:

- Labeled indications for a test approved or cleared by the FDA or indicated tests for an FDA approved Prescription Drug;
- Centers for Medicare and Medicaid Services (“CMS”) national coverage determinations or Medicare administrative contractor local coverage determinations;
- Nationally recognized clinical practice guidelines; or
- Peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for

scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

O. Maternity and Newborn Care.
We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. 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. See the Inpatient Services section of this Certificate for coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of renting one (1) breast pump per pregnancy for the duration of breast feeding from a Participating Provider or designated vendor.

We also Cover the outpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

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

Q. Outpatient Hospital Services:
We Cover Hospital services and supplies as described in the Inpatient Services section of this Certificate that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation. Unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests.

R. Preadmission Testing.
We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;

- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

S. Prescription Drugs for Use in the Office.
We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Certificate.

T. Rehabilitation Services.
We Cover Rehabilitation Services consisting of physical therapy, speech therapy, occupational therapy and pulmonary rehabilitation in the outpatient department of a Facility or in a Health Care Professional's office up to ninety (90) visits, per Plan Year. The visit limit applies to all habilitation and rehabilitation therapies combined.

We Cover speech and physical therapy only when:
- Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect); and
- The therapy is ordered by a Physician.

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 three hundred sixty-five (365) days after such event.

We also Cover Cardiac Rehabilitation for thirty-two (32) visits when performed in a Specialist Office or Outpatient Hospital Services.

U. Second Opinions.
1. **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.

2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.

3. **Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.

- The second opinion must be given by a board certified Specialist who personally examines You.
- If the first and second opinions do not agree, You may obtain a third opinion.
- The second and third surgical opinion consultants may not perform the surgery on You.

4. **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.

V. 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.

If Covered multiple surgical procedures are performed during the same operative session through the same or 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.

W. 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.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

X. 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. Breast or chest wall reconstruction surgery includes the tattooing of the nipple-areolar complex if such tattooing is performed by a Health Care Professional. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

Y. 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.

Z. 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. If You are Covered for Prescription Drugs under 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 physicians. Once access is obtained, You will be able to participate in a telemedicine consultation either online or by telephone with a telemedicine physician 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 the types of services available to you through the telemedicine program and applicable Cost-Sharing requirements.

AA. Transplants.

We Cover only those transplants determined to be non-experimental and non-investigational.

Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

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

See the Utilization Review and External Appeal sections of this Contract for Your right to an internal Appeal and external appeal of Our determination that a transplant must be performed at a designated Hospital.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. 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.

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, including batteries
   - 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 Covered only when obtained from a designated diabetic equipment or supply manufacturer which has an agreement with Us to provide all diabetic equipment or supplies required by law for Members through participating pharmacies. If You require a certain item not available from Our designated diabetic equipment or supply manufacturer, You, or Your Provider, must submit a request for a medical exception by calling the number on You ID card**.** Our medical director will make all medical exception determinations. Diabetic equipment and supplies are limited to a maximum of a ninety (90)-day supply when purchased at a pharmacy.

2. Self-Management Education.

Diabetes self-management education is 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 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 Contract. 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.

C. Hearing Aids.

1. Cochlear Implants.

We Cover bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Certificate. We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.

D. Hospice.
Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for two hundred-ten (210) days of Hospice Care. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

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

E. 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.

F. Prosthetics.

1. **External Prosthetic Devices.**
   We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

   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.

   Eyeglasses and contact lenses are not Covered under this section of the Certificate and are only Covered under the Vision Care section of this Certificate.

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

Coverage is for standard equipment only.

We Cover the cost of one (1) prosthetic device, per limb, per lifetime. We also Cover the cost of repair or replacement of the prosthetic device and its parts. 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.

2. **Internal Prosthetic Devices.**
We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

G. Shoe Inserts.

We Cover shoe inserts that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness. We Cover replacements: due to a change in Your condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

SECTION XI

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

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

The Cost-Sharing requirements in the Schedule of Benefits section of this Certificate apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital for the same or related causes that occur within a period of not more than ninety (90) days.

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

C. Inpatient Medical Services.
We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

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

We also Cover the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

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

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

G. Habilitation Services.
We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy for ninety (90) days period per Plan Year. The visit limit applies to all habilitation and rehabilitation therapies combined.

H. Rehabilitation Services.
We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for ninety (90) days per Plan Year. The visit limit applies to all habilitation and rehabilitation therapies combined.

We Cover speech and physical therapy only when:

1. Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect); and
2. The therapy is ordered by a Physician.

Covered Rehabilitation must begin within six (6) months of the later to occur:

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

I. Skilled Nursing Facility.

We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the "Exclusions and Limitations" section of this Certificate). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to unlimited days, per Plan Year, for non-custodial care.

J. End of Life Care.

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

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

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care service rates.
3. Or if it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rates.

K. Designated Hospitals.

Designated Hospitals are Hospitals that We have approved and designated for certain services. To find out if a Hospital is a designated Hospital call the number on Your ID card.

Our network of facilities includes designated Hospitals. We closely monitor the quality of Our provider network, assuring a high level of board certification. In addition, EmblemHealth looks to contract with providers who have achieved National Committee for Quality Assurance ("NCQA") medical home designation, offer electronic medical records, and facilities that have been designated as a designated Hospital by the Centers for Medicare and Medicaid Services ("CMS").

We provide case management for Members undergoing transplants and for those awaiting organ transplants. Through Our vendor relationships for In-Network access to designated transplant centers, We cover the following Services when performed at a designated Hospital.

- Bone marrow transplant
- Heart transplant
- Liver transplant
- Lung transplant
- Pancreas transplant
- Kidney transplant
- Bone marrow/stem cell transplant

See the Utilization Review and External Appeal sections of this Contract for Your right to an internal Appeal and external appeal if We determine that the above services must be performed at a designated Hospital.

L. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for you to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

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 medical and surgical benefits 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 or the most recent edition of another generally recognized independent standard of current medical practice such as the International Classification of Diseases.

1. Inpatient Services. We Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical, and surgical coverage provided under this Certificate. 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 Article 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 section 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. We Cover, upon the referral of a Physician, comprehensive neuropsychological examinations for dyslexia when performed by a Health Care Professional. Outpatient services also include nutritional counseling to treat a mental health condition.

   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 amount paid under the Medicaid program will not exceed the Non-Participating Provider's charge. The school-based mental health clinic shall not charge or seek reimbursement from You for outpatient services provided at a school-based mental health clinic except for Your 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, or 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.

   i. **Screening and Diagnosis.** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

   ii. **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; however, We Cover one (1) repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

iii. **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.

iv. **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.

v. **Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Contract.

vi. **Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.

vii. **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 Contract for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under Contract 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; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Contract 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 licensed, certified or otherwise authorized by the Office of Addiction Services and Supports ("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 of 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 use 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 and 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 twenty (20) outpatient visits per Plan Year for family counseling. A family member will be deemed to be covered, for the purpose 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.

C. Network Access for Mental Health Care and Substance Use Services.

1. Definitions.

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

- **Access Complaint**: Your complaint to Us when You cannot access a Participating Provider within the required Appointment Wait Time.
- **Appointment Wait Time**: The time from the initial request for outpatient mental health care or outpatient substance use-services to the earliest date offered for the appointment for services.

2. Network Provider Access

When You request an appointment for outpatient mental health care or outpatient substance

use services, a Participating Provider must offer You an appointment within the following Appointment Wait Times:

- Ten (10) business days for an initial appointment; and
- Seven (7) calendar days for an appointment following a discharge from a Hospital or an emergency room visit.

The above timeframes can be satisfied through a telehealth visit with a Participating Provider, unless You specifically request an in-person visit.

We have designated staff to assist You in finding a Participating Provider who can treat Your mental health condition or substance use disorder. You may contact Our designated staff by calling 1-888-447-2526 (or dial 711 for TTY/TDD).

If there is not a Participating Provider available within the Appointment Wait Time who can treat Your mental health condition or substance use disorder, You or Your designee may submit an Access Complaint to Us by calling 1-888-447-2526 (or dial 711 for TTY/TDD), by writing to us at Carelon BH, Attention: Complaints Department, PO Box 1850, Hicksville, NY 11802-1850, or by visiting Our website at https://www.carelonbh.com/emblemhealth/en/home/forms-and-documents#item_1.

Upon receipt of Your Access Complaint, We have three (3) business days to locate a Participating Provider who can (1) treat Your mental health condition or substance use disorder, (2) is able to meet the Appointment Wait Time, and (3) is located within a reasonable distance from You if You request an in-person appointment (rather than a telehealth appointment). If We cannot locate a Participating Provider who meets these requirements, We will:

- Notify You by telephone, if Your request was made by telephone, and in writing, that You may obtain an authorization to a Non-Participating Provider at the In-Network Cost-Sharing; and
- Approve an authorization to a Non-Participating Provider who:
    - Can treat Your mental health condition or substance use disorder;
    - Is able to meet the appointment Wait Time;
    - Is located within a reasonable distance from You if You request an in-person appointment; and
    - Charges rates that are not excessive or unreasonable.

The authorization will remain in effect until the earlier of the following:

- The services are no longer Medically Necessary; or
- We locate a Participating Provider who:
    - Can treat Your mental health condition or substance use disorder;
    - Is able to meet the Appointment Wait Time;
    - Is located within a reasonable distance from You if You request an in-person appointment; and
    - Your treatment can be transitioned to the Participating Provider, unless We determine, in consultation with Your treating Provider, as appropriate, that such transition would be harmful to You.

Covered Services rendered by the Non-Participating Provider will be Covered by Us as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing. Any Cost-Sharing that would have applied had the services been received from a Participating Provider will apply toward Your In-Network Out-of-Pocket Limit.

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 and the Grievance section of this Certificate for any other determination

SECTION XIII

Wellness Benefits

A. Wellness Program.

1. Purpose.
The purpose of this wellness program is to encourage You to take a more active role in managing Your health and well-being.

2. Description.
We provide benefits in connection with the use of or participation in any of the following wellness and health promotion actions and activities:

DISCOUNT PROGRAMS
The Healthy Discount programs are available to all EmblemHealth Members but are not a covered benefit under Your plan. We cannot guarantee the continued availability of any discount program or the continued participation of any discount program vendor. The offerings include:

- **Husk Wellness Discount Program Offerings**
  Achieving optimal health and wellness does not have to be complicated and expensive. With HUSK Marketplace, EmblemHealth members have access to exclusive best-in-class pricing with some of the biggest brands in fitness and wellness:
  Gym & Fitness Center Memberships – HUSK Marketplace members have access to exclusive savings and flexible membership options at thousands of fitness facilities. From national chains to specialty studios, HUSK has something for every type of workout.
  On-demand Fitness – Enjoy the benefits of group exercise classes in the comfort of Your own home. HUSK offers a variety of membership options for streaming workouts that allow You to take Your workout to the next level no matter where You are.
  Home Equipment & Tech – Whatever Your fitness level is, HUSK offers exclusive discounts on exercise equipment and wearable fitness trackers to help support You and Your goals in Your personal wellness journey.

  To find out more about these discount programs through Husk Marketplace, visit marketplace.huskwellness.com/emblemhealth.

- **Vision Discount Program** — You are eligible to access vision care, including examinations, eyewear, contact lenses and laser vision correction, at discounted rates through a network of vision providers. To locate discount program participating vision providers, go online at www.eyemed.com or call **1-844-790-3878**. To access the discount vision program services, contact a participating vision provider to schedule an appointment, identify yourself as Our Member and present Your ID card at the appointment. You must pay the full, discounted cost of the services that You receive under

this program directly to the participating provider. Services may vary by provider.

If Your Certificate includes coverage for certain vision care services or if such services are covered under an insurance plan that You have with another insurer, You should generally use Your insured vision benefit to access Covered Services, and only use this discount program to access non-covered services.

- **Hearing Care Discount Programs** — You are eligible to access discounts from the following selected vendors:

HearUSA/Hearx — Offers discounts of up to 20% on hearing aid purchases and up to 10% on listening products and hearing aid accessories. To identify participating locations where discounts apply, go online at www.hearusa.com/centers/search_criteria.asp?m=1&type=corporate&switch=no, or call **1-800-442-8231**. TTD users can call **1-888-300-3277**. To access the discounts for listening products and hearing aid accessories go to www.hearingshop.com. To receive the discount, view Your shopping cart and enter coupon code Emblem.

If Your Certificate includes coverage for hearing aids and/or listening products and hearing aid accessories or if these items are covered under another insurance plan if You are covered under more than one health plan, You should generally use Your insured hearing aid benefit, and only use this discount program to access non-covered hearing aid purchases.

To read more about these and other discount programs, visit www.emblemhealth.com/goodhealth.

CARE MANAGEMENT PROGRAMS

We offer programs designed to help Members with chronic conditions improve their health and well-being. To accomplish this goal, You can receive support and education from a specially trained nurse or other health care professional.

Care Management programs includes:

1. **Emergency Department (ED) Utilization** – A program designed to increase alignment of the care delivery system for Our high-need Members who have preventable ED visits. The goal of the program is to provide clinical oversight to reduce avoidable ED visits, engage Members in their primary care system, provide education to disease process and management and assist in care coordination to improve health outcomes. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

2. **Transitions of Care** – A program designed to prevent hospital readmissions through a comprehensive clinical program that provides Member education, ensuring post-discharge doctors' appointments, obtaining needed medications and understanding their usage, times of administration and signs and symptoms of concern to report, navigation for appropriate resources and assist in care coordination to meet health care needs. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

3. **Complex Case Management** – The Complex Case Management program provides intensive, personalized care management services and goal setting for members who have complex medical needs and require a wide range of resources to manage their health and improve quality of life. The goal of the program is to help members regain their optimum health in the right setting at the right time to promote self-management. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

4. **Transplant Program** – A program designed for Members who are in the process of receiving or being evaluated for transplant services. This includes collaboration with facilities and providers to ensure that Members obtain the best care while navigating through the transplant medical process. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

5. **IV Program** – A program that provides case management to support members living with HIV/AIDS that provides access to important supportive services, assistance and assists members in navigating the healthcare system. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

6. **Neonatal Intensive Care Unit (NICU) Program** – A program that provides a dedicated team of experienced NICU doctors, RN case managers and social workers to help support families during their baby's stay in the NICU and after they go home for one year. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

7. **Chronic Kidney Disease Management** – A program designed for Members with Chronic Kidney Disease ("CKD") Stages 4, 5 and End Stage Renal Disease ("ESRD"). The CKD portion of this program is designed to delay progression to dialysis by supporting and educating the member on the different disease stages. Our dedicated Renal care managers proactively recognize and respond to members living with renal disease. If dialysis is unavoidable, Members are assisted selecting the type of dialysis and provider that best meets their individual needs. To find out more or to enroll, call 866-561-7518, Monday to Friday, 9 a.m. to 5 p.m

WELLNESS PROGRAMS

1. **Tobacco Free Quit-Smoking Program** – A program designed to offer a telephonic-based behavior modification to Members that are eighteen (18) years old and older who want to stop smoking. The program consists of a comprehensive educational kit and support calls from a smoking cessation specialist. New York residents call **866-NY-QUITS** (866-697-8487), non- New York residents, call 877-500-2393 Monday to Friday, 8 a.m. to 9 p.m., Saturday, 9 a.m. to 7 p.m. and Sunday, 9 a.m. to 5 p.m. (**TTY: 711**).

2. **24-Hour Nurse Health Information Line** – A program designed to provide a 24-hour toll-free health information line that is staffed by highly-trained registered nurses and is available seven (7) days a week. Nurses trained in telephone triaging gives eligible Members access to immediate clinical support for everyday health issues and guide callers in making informed decisions about a multitude of health conditions and how best

to handle a medical concern. To find out more, call 877-444-7988.

3. **Healthy Beginnings Pregnancy Program** – A prenatal program designed to provide expectant mothers with important information about having a healthy pregnancy. The program conducts Obstetrical Risk Assessments. Members identified as high risk are referred to a complex care manager for further evaluation and intervention. To find out more, call 888-447-0337, Monday to Friday, 9 a.m. to 5 p.m.

4. **Vitality Wellspark (Foundation):** - A wellness platform to help Members create healthy habits, feel their best, and reduce their risk of preventable health conditions. Members have 24/7 access to wellbeing resources that include an online health assessment, activity tracking, robust health library, interactive learning resources and webinars.

   The Member has three (3) ways they can access the wellness platform:
   1. Through the Member portal https://my.emblemhealth.com/member/s/login/.
   2. Log in directly through www.powerofvitality.com.
   3. Download the Power of Vitality Health app.

   To find out more, call 877-224-7350, Monday to Friday, 9 a.m. to 5 p.m.

We also provide the following preventive health screening reminders and health management tools for Your convenience:

- **Preventive Health Screening Reminders** — You may receive mail, email and/or telephone reminders from Us to schedule important health screenings for breast, cervical and colorectal cancer, as well as other preventive health care messages. We post the recommended preventive health screening requirements appropriate for Your age or gender on our online portal at www.emblemhealth.com/en/Health-and-Wellness/Stay-Healthy/Health-Manager-Tools.aspx.
- **Health Management Tools** — Interactive online tools are available to You to help manage Your health and wellness at www.emblemhealth.com/en/Health-and-Wellness/Stay-Healthy/Health-Manager-Tools.aspx.
  - **A health risk assessment tool; Health Assessment (HA):** The Health Assessment includes approximately seventy-five (75) questions, based on individual risks and status, and takes You approximately thirty (30) minutes to complete. The assessment establishes a baseline of risks and provides a Health Score for You by collecting only essential data. The questions included in the HA have been validated through rigorous third-party research and is approved through the National Committee on Quality Assurance (NCQA). The HA evaluates Your physical health as well as Your social health, mental health and work-life balance – the key components in maintaining optimal wellness. Immediately following completion of the assessment, You are provided a summary report of Your health status, including a personalized Health Score indicating Your potential for improvement and related

health improvement opportunities. After completing the HA, You will receive a recommended digital coaching program to improve unhealthy behavior, impacting Your quality of life and health status.

Wellness Wearable Device Integration: We offer wellness tracker integration through our online portal at www.emblemhealth.com/en/Health-and-Wellness/Stay-Healthy/Health-Manager-Tools.aspx. The tracker is compatible with over one hundred (100) types of wellness wearable devices. Periodically synching up Your wearable device with the tracker will make it easier for You to track Your progress against Your goals.

Lifestyle Coaching: We offer telephonic health coaching to help You make lasting changes to Your lifestyle, including reducing risks and realizing improved quality of life.

Personal Health Record (PHR): Your health records are among Your most important documents. When You visit Our website at www.emblemhealth.com and sign in as a Member, You will be connected to myEmblemHealth, which provides resources to help You manage Your membership and Your health, including accessing Your health records and keeping them well organized and at Your fingertips. You can also retain a concise record of Your medications, medical history, tests, health care contacts and more in Your personal health record, as well as elect to have Your prescription records automatically added to Your PHR. You can even print out copies of Your PHR to share with Your doctor(s).

3. Eligibility.
You, the Subscriber, and each covered Dependent can participate in the wellness program.

4. Participation.
The preferred method for accessing the wellness program is through Our website at http://www.emblemhealth.com/en/Health-and-Wellness.aspx. You need to have access to a device with internet access in order to participate in the website program. However, if You do not have internet access, please call Us at the number on Your ID card and We will provide You with information regarding how to participate without internet access.

SECTION XIV

Vision 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.

A. Vision Care.
We Cover emergency, preventive and routine vision.

B. Vision Examinations.
We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time in any twelve (12)-month; period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

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

C. Prescribed Lenses and Frames.
We Cover standard prescription lenses, one (1) time in any twenty-four (24)-month period, unless it is Medically Necessary for You to have new lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames adequate to hold lenses one (1) time in any twenty-four (24)-month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. You must choose the frames and lenses from a select group at any Participating Provider. If You choose a non-standard frame, We will pay the amount that We would have paid for a standard frame and You will be responsible for the difference in cost between the standard frame and the non-standard frame.

The difference in cost does not apply toward Your Out-of-Pocket Limit**.**

SECTION XV

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 Appeals 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 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(s) 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, or 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 Appeals section 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).

H. 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.

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

J. 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.

K. 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. 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.

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

M. 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.

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

O. 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.

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

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

R. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Vision Care section of this Certificate.

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

T. 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 XVI

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 in the How Your Coverage Works section of this Certificate. 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.

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.

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 section 238-a(1) of the New York Public Health Law.

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 and Referrals. 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 Appeals 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 or Referral), 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 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 XVII

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 833-269-4653 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 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 833-269-4653 or visit Our website 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 the 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 a 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 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 833-269-4653, in person, or in writing. However, Urgent Appeals may be filed by phone. 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 has not yet been provided.)	Fifteen (15) calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or a 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	Thirty (30) business days of receipt of all necessary information to make a determination.

or request for service or treatment.)

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 Health at 1-800-206-8125 or write them at:
New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237
Email: managedcarecomplaint@health.ny.gov
Website: www.health.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 XVIII

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, or, for mental health and substance use disorder services, 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.** Services provided by participating crisis stabilization

centers licensed under Mental Hygiene Law section 36.0, 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 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 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 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 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 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 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 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 include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. 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 Referral Denial**. You also have the right to Appeal the denial of a request for a Referral 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 Referral 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. First Level Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within fifteen (15) 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 fifteen (15) 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 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.

1. **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.

2. **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. Second level Appeal.

If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external appeal. **The four (4) month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external appeal.**

A second level Appeal must be filed within forty-five (45) days of receipt of the final adverse determination on the first level Appeal. We will acknowledge Your request for an internal Appeal within fifteen (15) calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and inform You, if necessary, any additional information needed before a decision can be made.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within fifteen (15) 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 fifteen (15) 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 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.

3. **Expedited Appeal.** If Your Appeal relates to an urgent matter, We will decide the Appeal and provide written notice of the determination to You (or Your designee), and where appropriate, Your Provider, within seventy-two (72) hours of receipt of the Appeal request.

L. 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 XIX

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 the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of 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 Referral Denial to a Non-Participating Provider.

If We have denied coverage of a request for a Referral 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 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 the first level of 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 costs of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Certificate for non-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 ($25) for each external appeal, not to exceed seventy-five ($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 XX

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. We do not coordinate benefit payments for vision benefits.

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 benefits 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 shall 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 XXI

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 end of the month in 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 has 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 date 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/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 and the Conversion Right to a New Contract After Termination section of this Certificate for Your right to conversion to an individual Contract.

SECTION XXII

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 XXIII

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 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 XXIV

Conversion Right To 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. The coverage may not be the same as your current coverage.

SECTION XXV

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 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 to an 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. 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 is in conflict 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 ERISA.

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 may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA") as amended. The "plan administrator" is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

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 that 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. Input in Developing Our Policies.

Subscribers may participate in the development of Our policies by writing to Our Customer Service address, **EmblemHealth, Customer Service Department, 55 Water Street, New York, NY 10041-8190**; e-mail Us by visiting www.emblemhealth.com, or calling Us at the number on Your ID card.

15. Material Accessibility.

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

16. 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.

17. Notice.

Any notice that We give to 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: EmblemHealth, 55 Water Street, New York, NY 10041.

18. Premium Refund.

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

19. Recovery of Overpayments.

On occasion, a payment will be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 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.

20. 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 as permitted by this Certificate or by the Group.

21. 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.

22. 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.

23. Severability.

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

24. 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.

25. 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 Section 5-335 of the New York General Obligations Law, 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.

26. 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.

27. 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.

28. Translation Services.

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

29. 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.

30. 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.

31. 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.

32. 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 You or the Provider. However, We will directly pay a Provider instead of You for Emergency Services, including inpatient services following Emergency Department Care, pre-hospital emergency medical services, air ambulance services, and surprise bills. For pre-hospital emergency medical services, and emergency ground and water ambulance transportation, 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.

33. 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.

34. 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.

35. 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 XXVI

HIP HMO Preferred
Schedule of Benefits

COST-SHARING	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Equipment and Devices Deductible	$0	$0	Non-Participating Provider services are not Covered except as required for emergency care	
Plan Year Out-of-Pocket Limit • Individual • Family Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a Plan Year basis.	$3,300 $6,600	$3,300 $6,600	Non-Participating Provider services are not Covered except as required for emergency care	

OFFICE VISITS * Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	**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, not subject to Deductible	$10 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits) **Referral Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	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	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Adult Immunizations*	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

PREVENTIVE CARE- Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer*	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Sterilization Procedures for Women*	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Vasectomy	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Bone Density Testing*	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Prostate Cancer Screening	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Colon Cancer Screening	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

PREVENTIVE CARE- Continued	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• All other preventive services required by USPSTF and HRSA	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• *When preventive 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)	Non-Participating Provider services are not Covered and You pay the full cost	

EMERGENCY CARE * Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance)	$0 Copayment	$0 Copayment	$0 Copayment	See benefit for description
Non-Emergency Ambulance Services (Ground and Air Ambulance) **Preauthorization Required**	$0 Copayment	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency Department Copayment waived if Hospital admission	$150 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$150 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$150 Copayment	See benefit for description
Urgent Care Center	$50 Copayment	$50 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE * Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	**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				See benefit for description
• Performed in a Specialist Office **Preauthorization Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility **Preauthorization Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization Required**	$100 Copayment	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Allergy Testing and Treatment • Performed in a PCP Office	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Specialist Office **Referral Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Ambulatory Surgical Center Facility Fee	$50 Copayment	$50 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings)	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Thirty-two (32) visits when performed in a Specialist Office or Outpatient Hospital Services
• Performed as Outpatient Hospital Services	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Inpatient Hospital Services **Preauthorization required**	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE - Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Chemotherapy and Immunotherapy				
• Performed in a PCP Office	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Scalp Cooling Systems	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
Chiropractic Services	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Clinical Trials **Preauthorization Required**	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE - Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Diagnostic Testing • Performed in a PCP Office **Preauthorization Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Specialist Office **Preauthorization Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization Required**	$100 Copayment	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Dialysis • Performed in a PCP Office	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year **Preauthorization Required** Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information
• Performed in a Specialist Office **Referral Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Center	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	90 visits per Plan Year combined therapies Limit(s) applies to all habilitation and rehabilitation therapies combined The visit limit does not apply to Habilitation Services for a mental health condition or substance use disorder.
• Performed in a Specialist Office	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in an Outpatient Facility	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Home Health Care **Preauthorization required**	$0 Copayment	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	200 visits per Plan Year The visit limit does not apply to Home Health Care for a mental health condition or substance use disorder.
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)	Non-Participating Provider services are not Covered and You pay the full cost	See benefit description
Infusion Therapy • Performed in a PCP Office • Performed in a Specialist Office **Referral Required**	$0 Copayment $0 Copayment	$10 Copayment $10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Infusion Therapy (continued) • Performed as Outpatient Hospital Services **Preauthorization Required** • Home Infusion Therapy **Preauthorization Required**	$100 Copayment $0 Copayment	$100 Copayment $0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	
Inpatient Medical Visits	$0 Copayment	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Interruption of Pregnancy • Abortion Services	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Laboratory Procedures • Performed in a PCP Office **Preauthorization required** • Performed in a Specialist Office **Preauthorization required**	$0 Copayment $0 Copayment	$10 Copayment $10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Laboratory Procedures **(c**ontinued) • Performed in a Freestanding Laboratory Facility **Preauthorization required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$100 Copayment	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Maternity and Newborn Care • Prenatal Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Prenatal 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)	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Maternity and Newborn Care (continued)				
• Inpatient Hospital Services and Birthing Center **Preauthorization Required**	$100 Copayment, not subject to Deducible	$100 Copayment, not subject to Deducible	Non-Participating Provider services are not Covered and You pay the full cost	
• Physician and Midwife Services for Delivery	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Covered for duration of breast feeding
• Postnatal Care • Postnatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Postnatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Maternity and Newborn Care (continued) • Outpatient Donor Breast Milk **Preauthorization required for Inpatient Services**	Covered in full	Covered in full		
Outpatient Hospital Surgery Facility Charge	$150 Copayment	$150 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing **Preauthorization Required**	$0 Copayment	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prescription Drugs Administered in Office				See benefit for description
• Performed in a PCP Office	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diagnostic Radiology Services				See benefit for description
• Performed in a PCP Office	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Preauthorization Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility **Preauthorization Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization Required**	$100 Copayment	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Therapeutic Radiology Services • Performed in a Specialist Office **Preauthorization Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Freestanding Radiology Facility **Preauthorization Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech Therapy or Pulmonary Rehabilitation)				Ninety (90) visits per Plan Year. Combined therapies. Limit(s) applies to all habilitation and rehabilitation therapies combined Speech and physical therapy are only Covered following a Hospital stay or surgery The visit limit does not apply to Rehabilitation Services for a mental health condition or substance use disorder.
• Performed in a PCP office	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist office	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in an Outpatient Facility	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	Limits
Second Opinions on the Diagnosis of Cancer, Surgery and Other **Referral Required**	$0 Copayment	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost 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
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)				See benefit for description
• Inpatient Hospital Surgery **Preauthorization Required**	$0 Copayment	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	**All Transplants must be performed at designated Hospitals**
• Outpatient Hospital Surgery **Preauthorization Required**	$0 Copayment	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center **Preauthorization Required**	$0 Copayment	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants) (Continued) • Office Surgery Performed in a PCP Office **Preauthorization Required** Performed in a Specialist Office **Preauthorization Required**	$0 Copayment $0 Copayment	$0 Copayment $0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	
Telemedicine Program • Virtual General Medical Session available 24/7 on demand Provided by a Telemedicine Physician	$10 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

ADDITIONAL BENEFITS, EQUIPMENT and DEVICES * Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	**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				See benefit for description
• Retail Diabetic Equipment and, Supplies (30-day supply) **Preauthorization required**	$0 Copayment	$10 Copayment,	Non-Participating Provider services are not Covered and You pay the full cost	
• Diabetic Insulin (30-day supply)	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Oral anti diabetic agents and injectable anti-diabetic agents (30-day supply) **Preauthorization required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

ADDITIONAL SERVICES, EQUIPMENT and DEVICES (continued)	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 (continued) • Mail Order Diabetic Equipment and Supplies (90-day supply) **Preauthorization required** • Mail Order Diabetic Insulin (90-day supply) • Diabetic Education	$0 Copayment Covered in full $0 Copayment	$10 Copayment Covered in full $10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Durable Medical Equipment and Braces **Preauthorization Required**	$0 Deductible	$0 Deductible	Non-Participating Provider services are not Covered and You pay the full cost	The Deductible is combined for Durable Medical Equipment and Braces, Prosthetics, and Shoe Inserts.
Cochlear Implants	$0 Deductible	$0 Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered

ADDITIONAL SERVICES, EQUIPMENT and DEVICES - Continued	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Hospice Care • Inpatient **Preauthorization Required** • Outpatient	$0 Copayment $0 Copayment	$0 Copayment $0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	Two hundred ten (210) days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies **Preauthorization Required**	$0 Copayment	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices • External **Preauthorization Required** • Internal	$0 Deductible Included as part of inpatient Hospital Service Cost-Sharing	$0 Deductible Included as part of inpatient Hospital Service Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements The Deductible is combined for Durable Medical Equipment and Braces, Prosthetics, and Shoe Inserts Unlimited; See benefit for description

ADDITIONAL SERVICES, EQUIPMENT and DEVICES - Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Shoe Inserts **Preauthorization Required**	$0 Deductible	$0 Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description The Deductible is combined for Durable Medical Equipment and Braces, Prosthetics, and Shoe Inserts

INPATIENT SERVICES * Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Autologous Blood Banking	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) **Preauthorization required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.**	$100 Copayment	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

INPATIENT SERVICES - Continued	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Observation Stay	$50 Copayment	$50 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization Required**	$0 Copayment	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited days per Plan Year The visit limit does not apply to Skilled Nursing Facility for a mental health condition or substance use disorder.
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization Required**	$100 Copayment	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	90 days per Plan Year combined therapies Limit(s) applies to all habilitation and rehabilitation therapies combined The visit limit does not apply to Inpatient Habilitation Services for a mental health condition or substance use disorder.

INPATIENT SERVICES - Continued	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy) **Preauthorization Required**	$100 Copayment	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	90 days per Plan Year combined therapies. Limit(s) applies to all habilitation and rehabilitation therapies combined Speech and physical therapy are only Covered following a Hospital stay or surgery The visit limit does not apply to Inpatient Rehabilitation Services for a mental health condition or substance use disorder.

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. However, preauthorization is not required for emergency admissions or for admissions at Participating Hospitals or crisis residence facilities licensed or operated by OMH.**	$100 Copayment	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES - Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• All Other Outpatient Services • Outpatient Services provided in a Facility licensed, certified, or otherwise authorized by OMH	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• All Other Outpatient Services **Preauthorization required for partial hospitalization services. Preauthorization is not required for participating crisis stabilization centers licensed by OMH.**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
ABA Treatment for Autism Spectrum Disorder **Preauthorization Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES - Continued	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Assistive Communication Devices for Autism Spectrum Disorder **Preauthorization Required**	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating Facilities licensed, certified or otherwise authorized by OASAS.**	$100 Copayment	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES - Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)				Unlimited; Up to twenty (20) visits per Plan Year may be used for family counseling
• Office Visits	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• All Other Outpatient Services • Opioid Treatment Programs	Covered in full	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• All Other Outpatient Services	$0 Copayment	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Preauthorization required for partial hospitalization services. Preauthorization is not required for participating Facilities licensed, certified or otherwise authorized by OASAS .				

Vision Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Vision Care • Refractive Eye Exam with dilation as necessary	$0 Copayment	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	One (1) exam per twelve (12) month period
• Frames	$80 allowance, 20% discount on balance over allowance	$80 allowance, 20% discount on balance over allowance		One (1) prescribed frames per 24-month period; Plan Year
• Standard Plastic Lenses	$35 Copayment	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	One (1) prescribed lenses per 24-month period
• Standard Progressive Lenses	$100 Copayment	$100 Copayment		
• Premium Progressive Lenses	$100 Copayment, 20% discount on balance over $120 allowance	$100 Copayment, 20% discount on balance over $120 allowance		

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.

SECTION XXVII

Domestic Partner Rider

A. Domestic Partner Coverage.
This rider amends Your Certificate to provide coverage for domestic partners. This rider covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under the 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 eighteen (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; and
   b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
   c. Proof that the partners are financially interdependent. Two (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.

B. Controlling Certificate.
All of the terms, conditions, limitations, and exclusions of Your Certificate to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

HEALTH INSURANCE PLAN OF GREATER NEW YORK

Michael Palmateer

Michael Palmateer
Chief Executive Officer

SECTION XXVIII

Private Duty Nursing Rider

Covered Services. Private Duty Nursing care will be provided during a Hospital admission that is covered under this Certificate. Private Duty Nursing must be skilled care and must be provided by a graduate nurse or a licensed practical nurse who is not a relative of or resides with the Member. Nurse's aide services are not covered, regardless of why a nurse's aide was used, even if ordered by a Physician.

Benefit Limitations. Private Duty Nursing benefits will be provided without charge to the Member.

All other terms, conditions, limitations and exclusions of the HIP Contract/Certificate of Coverage apply to the benefits provided by this Rider.

HEALTH INSURANCE PLAN OF NEW YORK

Michael Palmateer

Michael Palmateer
Chief Executive Officer

Section XXIX

Prescription Drug

This Rider amends Your Certificate to provide benefits for the Covered Services described below.

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.

Covered Prescription Drugs include, but are not limited to the drugs described below. If the Prescription Drug or item prescribed to You is covered under the City of New York PICA program, then Your coverage for that Prescription Drug or item will be provided under the PICA program and not under this Rider. If the Prescription Drug or item prescribed to You is covered under another section of this Certificate, then Your coverage for that Prescription Drug or item will be provided under the other section of this Certificate and not under this Rider.

- Self-injectable/administered Prescription Drugs, including epinephrine auto-injector devices for the emergency treatment of life-threatening allergic reactions.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- 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, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit, including in vitro fertilization, and fertility preservation services in the Outpatient and Professional Services section of this Certificate.
- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription drugs for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to prevent HIV infection.
- Prescription Drugs for the treatment of mental health and substance use disorders, 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.
- 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. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. 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 if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, 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 1-855-283-2150 to get a copy of the form or to find out more about this exception process.

You may request a copy of Our Formulary. Our Formulary is also available on Our website at www.emblemhealth.com. You may inquire if a specific drug is Covered under this Certificate by contacting Us at 1-855-283-2150.

A. Refills.

We Cover Refills of Prescription Drugs only when dispensed at a retail, mail order or designated pharmacy as ordered by an authorized Provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Certificate.

C. Benefit and Payment Information.

1. Cost-Sharing Expenses. Your Cost-Sharing for Prescription Drugs is as follows:

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. * Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy				
30-day supply Tier 1	20% Coinsurance, but not less than a $5 Copayment	20% Coinsurance, but not less than a $5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Retail Pharmacy (continued) Tier 2	40% Coinsurance, but not less than a $25 Copayment	40% Coinsurance, but not less than a $25 Copayment	The Deductible, if applicable, does not apply to preventive Prescription Drugs used to manage asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke. Visit Our website at www.emblemhealth.com or call 1-855-283-2150 to find out if a particular Prescription Drug is on the preventive drug list.	
Tier 3 Preauthorization is not required for Covered antiretroviral Prescription Drugs for the treatment or prevention of HIV or AIDS and Prescription Drugs used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	50% Coinsurance, but not less than a $40 Copayment Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Plan Year	50% Coinsurance, but not less than a $40 Copayment Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Plan Year	Non-Participating Provider services are not Covered and You pay the full cost	

PRESCRIPTION DRUGS (Continued)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Mail Order Pharmacy				
Up to a 90-day supply Tier 1	$12.50 Copayment	$12.50 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	The mail order pharmacy Cost-Sharing will apply to Prescription Drugs obtained at a retail Participating Pharmacy that agrees to the same reimbursement amount as the mail order pharmacy.
Tier 2	$50 Copayment	$50 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Tier 3	$75 Copayment Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Plan Year	$75 Copayment Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Plan Year	Non-Participating Provider services are not Covered and You pay the full cost	

PRESCRIPTION DRUGS (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Enteral Formulas				See benefit for description
Tier 1	20% Coinsurance, but not less than a $5 Copayment	20% Coinsurance, but not less than a $5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Tier 2	40% Coinsurance, but not less than a $25 Copayment	40% Coinsurance, but not less than a $25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Tier 3	50% Coinsurance, but not less than a $40 Copayment	50% Coinsurance, but not less than a $40 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

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.

For most Prescription Drugs, You pay only the Cost-Sharing in the Schedule of Benefits. An additional charge, called an "ancillary charge," may apply to some Prescription Drugs when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request and Our Formulary includes a chemically equivalent Prescription Drug on a lower tier. You will pay the difference between the full cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference is not Covered and must be paid by You in addition to the lower tier Cost-Sharing. If Your Provider thinks that a chemically equivalent Prescription Drug on a lower tier is not clinically appropriate, You, Your designee or Your Provider may request that We approve coverage at the higher tier Cost-Sharing. If approved, You will pay the higher tier Cost-Sharing only. If We do not approve coverage at the higher tier Cost-Sharing, You are entitled to an Appeal as outlined in the Utilization Review and External Appeal sections of this Certificate. The request for an approval should include a statement from Your Provider that the Prescription Drug at the lower tier is not clinically appropriate (e.g., it will be or has been ineffective or would have adverse effects.) We may also

request clinical documentation to support this statement. If We do not approve coverage for the Prescription Drug on the higher tier, the ancillary charge will not apply toward Your Out-of-Pocket Limit.

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

Coupons and Other Financial Assistance. We will apply any third-party payments, financial assistance, discounts, or other coupons that help You pay Your Cost-Sharing towards Your Deductible and Out-of-Pocket Limit.

This provision only applies to: 1) a Brand-Name Drug without an AB-rated generic equivalent, as determined by the FDA; 2) 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 3) all Generic Drugs.

1. **Participating Pharmacies.** For Prescription Drugs purchased at a retail, mail order or designated Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug. (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required In-Network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at 1-855-283-2150 or visit Our website at www.emblemhealth.com to request approval.

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

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

- Antiparkinson Agents;
- Biologics;
- Biosimilars;
- Bisphosphonates;
- Cardiovascular;
- Coagulation Therapy;
- Crohn's disease;
- Cystic fibrosis;
- Endocrine disorders/neurologic disorders such as infantile spasms;
- Enzyme deficiencies/liposomal storage disorders;
- Fertility;
- Gaucher's disease;
- Growth hormone;
- Hepatitis medications;
- Hereditary angioedema;
- HIV/AIDS;
- Immunomodulators;
- Iron overload;
- Iron toxicity;
- Multiple sclerosis;
- Neurological therapy medications;
- Oncology medications;
- Ophthalmic medication;
- Orphan drugs;
- Parkinson's disease;
- Psychotherapeutic drugs;
- Pulmonary agents;
- Pulmonary arterial hypertension;
- Rheumatologic and related conditions
- Transplant;
- Vaccines

4. **Designated Retail Pharmacy for Maintenance Drugs.** You may also fill Your Prescription Order for Maintenance Drugs for up to a 90-day supply at a Designated retail Pharmacy.
   You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

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

   To maximize Your benefit, ask Your 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).

   Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:
   - Asthma;
   - Behavioral Health;
   - Blood pressure;
   - Diabetes;
   - High cholesterol;
   - Other maintenance drugs

   You or Your Provider may obtain a copy of the list of Prescription Drugs available through a Designated retail Pharmacy by visiting Our website at www.emblemhealth.com or by calling 1-855-283-2150. The Maintenance Drug list is updated periodically. Visit Our website at www.emblemhealth.com or call 1-855-283-2150 to find out if a particular Prescription Drug is on the maintenance list.

6. **Mail Order.** Except as described below, Certain Prescription Drugs may be ordered through Our mail order pharmacy. You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

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

   To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a ninety (90)-day supply, with Refills when appropriate (not a thirty (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 supplier regardless of the number of days supply written on the Prescription Order or Refill.

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

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website www.emblemhealth.com or by calling 1-855-283-2150.

7. **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 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.

8. **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 ninety (90) days' notice prior to the start of the Plan Year. We will also post such notice on Our website 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 1-855-283-2150

9. **Formulary Exception Process.** If a Prescription Drug 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 this Certificate. Visit our website at www.emblemhealth.com or by calling 1-855-283-2150 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 and in writing no later than seventy-two (72) hours after Our 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 and in writing no later than twenty-four (24) hours after Our 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.

10. **Supply Limits:** Except for contraceptive drugs and devices, We will pay for no more than a ninety (90)-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a thirty (30)-day supply. However, for Maintenance Drugs We will pay for up to a ninety (90)-day supply of a drug purchased at a retail pharmacy. You are responsible for up to three (3) Cost-Sharing amounts for a ninety (90)-day supply at a retail pharmacy.

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

    Benefits will be provided for Prescription drugs dispensed by a mail order pharmacy in a quantity of up to a ninety (90)-day supply. You are responsible for one (1) Cost-Sharing amount for a thirty (30)-day supply up to a maximum of three (3) Cost-Sharing amounts for a ninety (90)-day supply.

    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 www.emblemhealth.com or by calling 1-855-283-2150. 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 this Certificate.

11. **Initial Limited Supply of Prescription Opioid Drugs.** If You receive an initial limited

prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be the same Copayment that would apply to a thirty (30)-day supply of the Prescription Drug. If You receive an additional supply of the Prescription Drug within the same thirty (30)-day period in which You received the seven (7) day supply, You will not be responsible for an additional Copayment for the remaining thirty (30)-day supply of that Prescription Drug.

12. **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 III controlled substances.

13. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is at least as favorable to You as the Cost-Sharing amount if any, that applies to intravenous or anticancer medications Covered under the Outpatient and Professional Services section of this Certificate.

14. **Split Fill Dispensing Program.** The split fill dispensing program is designed to prevent wasted Prescription Drugs if Your Prescription Drug or dose changes or if We contact You and You confirm that You have leftover Prescription Drugs from a previous fill. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get a fifteen (15)-day supply of Your Prescription Order for certain drugs filled at a pharmacy instead of the full Prescription Order. You initially pay half the thirty (30)-day Cost-Sharing. The therapeutic classes of Prescription Drugs that are included in this program are: Antivirals/Anti-infectives, Multiple Sclerosis, and Oncology. This program applies for the first sixty (60) days when You start a new Prescription Drug. This program will not apply upon You or Your Provider's request. You or Your Provider can opt out by visiting Our website at www.emblemhealth.com or by calling 1-855-283-2150.

B. Medical Management

This Certificate 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 Covered antiretroviral Prescription Drugs for the treatment or prevention of HIV or AIDS and medications to

treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

Prescription Drugs in the drug classes listed below are also subject to Preauthorization. Examples of common drugs in the class are listed with each class.

- **Anti-Depressant Medications**, such as: Aplenzin; Paxil/Paxil CR; Fluvoxamine ER, and Trintellix.
- **Anti-Fungal Agents**, such as: Cresemba, Noxafil and Vfend.
- **Appetite Suppressants**, such as: Adipex-P; Xenical; Benzphetamine hydrochloride; and Phentermine hydrochloride.
- **Blood Pressure Medications**, such as: Adalat CC; Calan SR; Tenoretic 100; Tenoretic 50; and Verelan
- **Cholesterol Lowering Medications**, such as: Caduet; and Lescol XL.
- **Diabetic Medications**, such as: Actos; Farxiga; Trulicity; Steglatro; Steglujan; Segluromet; Januiva; Janumet; Janumet XR; Jardiance; Ozempic; Rybelsus and Oseni.
- **Eczema Medications**, such as: Eucrisa; and Protopic.
- **GI Medications that Block Acid Secretion**, such as: Prevacid 24HR Prilosec OTC; Zegerid OTC
- **Hepatitis C Medications**, such as: Harvoni; Epclusa; Vosevi; Zepatier; and Viekira Pak.
- **Migraine Medications**, such as: Amerge; Frova; Nurtec ODT; Reyvow; Ubrelvy;; and Zomig Nasal.
- **Narcotics/Opiods**, such as: Dilaudid; MS Contin; Oxyado; OxyContin; and Actiq.
- **Osteo-Arthritis/Anti-Inflammatory Medication**, such as: Indocin; Relafen and Naprelan CR.
- **Vitamin A Based Medications for Treatment of Cystic Acne**, such as: Adapalene and Differin.

For a complete list of Prescription Drugs that need Preauthorization, please visit Our website at www.emblemhealth.com or call 1-855-283-2150. 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 try and fail on up to two (2) Prescription Drugs to treat Your medical condition or disease 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. We will not require You to use a Prescription Drug that has not been approved by the FDA for Your medical condition or is not supported by current evidence-based guidelines for Your medical condition. We will not apply the step therapy protocol if a therapeutic equivalent to the requested Prescription Drug is not available or if We have documentation that We have Covered the requested Prescription Drug for You in the last 365 days. The step-therapy protocol will not apply for more than thirty days, or the duration of treatment supported by current evidence-based treatment guidelines for Your medical condition. If You are newly enrolled under this Certificate and You completed a step therapy protocol for the requested Prescription Drug with a previous health plan within the last 365 days and You or Your Provider submits information to Us demonstrating completion of the step therapy protocol, Our step therapy protocol will not apply to the requested Prescription Drug. 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 this Certificate. If We Cover a Prescription Drug following a step therapy override determination, then a Formulary change or any medical management change will not require You to complete our step therapy protocol until Your override determination expires, unless there exists a specifically identified and current evidence-based safety concern and a therapeutic alternative Prescription Drug exists. 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.

C. Limitations/Terms of Coverage.

3. 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.

4. 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 thirty-one (31) days of the date We notify You, We will select a single Participating Pharmacy for You.

5. Compounded Prescription Drugs will be Covered only when the primary ingredient is a Covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs require Your Provider to obtain Preauthorization.

4. Various specific and/or generalized “use management” protocols will be used from time

to time in order to ensure appropriate utilization of Prescription Drugs. 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.

5. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Certificate.

6. 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 the Outpatient and Professional Services section of this Certificate.

7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs for which there is a written order, 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 for which there is a written order, or as otherwise provided in this Certificate. 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 or more Prescription Drug(s) and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients**.**

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

9. 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.

10. 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 this Certificate.

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

D. 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. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

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

E. Definitions

Terms used in this section are defined as follows. (Other defined terms can be found in the definitions section of this 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 Certificate. To determine which tier a particular Prescription Drug has been assigned, visit Our website www.emblemhealth.com or by calling 1-855-283-2150.

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. **Maintenance Drug:** A Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drugs.

6. **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.

7. **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.

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

8. **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.

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

10. **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.

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

H. Controlling Certificate.

All of the terms, conditions, limitations, and exclusions of Your Certificate to which this Rider is attached shall also apply to this rider except where specifically changed by this Rider.

Health Insurance Plan of Greater New York

Michael Palmateer

Michael Palmateer
Chief Executive Officer

SECTION XXX

Transportation, Lodging, And Meal Expenses For Transplants Rider

This Rider amends the Definitions and Outpatient and Professional Services sections of the Certificate of Coverage as described below:

I. The following definition is added to the Certificate of Coverage.

Definitions
"Benefit Period" means, with respect to any Covered Transplant Procedure, the 366-day period beginning one (1) day immediately prior to the date on which the Covered Transplant Procedure occurs. In the case of a covered bone marrow transplant procedure, the transplant procedure will be deemed to have occurred on the day of re-infusion for the first transplant procedure, regardless of whether such transplant may be the first of a series of such transplants that comprise a single, discrete treatment plan.

II. The following provision is added to the Outpatient and Professional Services section of the Certificate of Coverage.

Transportation, Lodging, And Meal Expenses
Coverage for transportation, lodging, and meals shall be limited to reasonable, out-of-pocket expenses which are actually incurred. The maximum overall coverage shall be $10,000 per Covered Transplant Procedure. The maximum daily coverage for lodging and meals shall be $200 per day.
Expenses for transportation, lodging, and meals are covered for the transplant recipient and his or her companion (two, if the candidate is a minor) when traveling outside of a fifty (50) mile radius from the recipient's home. Coverage is also offered for transportation, lodging and meals for the transplant donor and one companion (two if the donor is a minor) when traveling outside of a fifty (50) mile radius from the donor's home.
Transportation, lodging, and meals expenses will be reimbursed at transplant evaluation.
Transportation, lodging and meal receipts are required for reimbursement (unless travel is by personal automobile in which case mileage is reimbursed at the applicable IRS rate).
There is no coverage for the following expenses:

- Any expenses for anyone other than the transplant recipient and designated traveling companion (two, if the candidate is a minor).
- Any transportation, lodging, and meals expenses incurred when receiving care from an out-of-network provider.
- Any expenses other than the transportation, lodging and meals described in this provision.
- Expenses over the total per day limits for lodging and meals or the overall $10,000 limit.

All other terms, conditions, limitations and exclusions of the Contract/Certificate of Coverage apply to the benefits provided by this Rider.

Signed for Health Insurance Plan of Greater New York

Michael Palmateer

Michael Palmateer
Chief Executive Officer

SECTION XXXI

Preferred Prescription Drug Coverage

City of New York

This Rider amends Your Certificate to provide benefits for the Covered Services described below.

Prescription Drug Coverage

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

Your union welfare fund may provide similar benefits. If this is the case, the similar benefits provided by Your union welfare fund will be covered only through Your union welfare fund and not under this rider. The City of New York Employee Benefits Program will determine whether Your union welfare fund provides similar benefits and notify Us. We do not make this determination.

F. Covered Prescription Drugs.

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

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

Covered Prescription Drugs include, but are not limited to the drugs described below. If the Prescription Drug or item prescribed to You is covered under the City of New York PICA program, then Your coverage for that Prescription Drug or item will be provided under the PICA program and not under this Rider. If the Prescription Drug or item prescribed to You is covered under another section of this Certificate, then Your coverage for that Prescription Drug or item will be provided under the other section of the Certificate and not under this Rider.

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.

- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit, including invitro fertilization, and fertility preservation services in the Outpatient and Professional Services section of the Certificate.
- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription Drugs for pre-exposure prophylaxis (PrEP) PrEP) and post-exposure prophylaxis (PEP) to prevent HIV infection.
- Prescription Drugs for the treatment of mental health and substance use disorders 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.
- Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. 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 if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider.
- 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, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.

You may request a copy of Our Formulary. Our Formulary is also available on Our website at www.emblemhealth.com. You may inquire if a specific drug is Covered under the Certificate by contacting Us at 1-855-283-2150.

G. Refills.

We Cover Refills of Prescription Drugs only when dispensed at a retail, mail order or designated pharmacy as ordered by an authorized Provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of the Certificate.

H. Benefit and Payment Information

12. **Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Schedule of Benefits section of the Certificate when Covered Prescription Drugs are obtained from a retail, mail order or designated pharmacy.

    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.

    For most Prescription Drugs, You pay only the Cost-Sharing in the Schedule of Benefits. An additional charge, called an "ancillary charge," may apply to some Prescription Drugs when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request and Our Formulary includes a chemically equivalent Prescription Drug on a lower tier. You will pay the difference between the full cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference is not Covered and must be paid by You in addition to the lower tier Cost-Sharing. If Your Provider thinks that a chemically equivalent Prescription Drug on a lower tier is not clinically appropriate, You, Your designee or Your Provider may request that We approve coverage at the higher tier Cost-Sharing. If approved, You will pay the higher tier Cost-Sharing only. If We do not approve coverage at the higher tier Cost-Sharing,

You are entitled to an Appeal as outlined in the Utilization Review and External Appeal sections of the Certificate. The request for an approval should include a statement from Your Provider that the Prescription Drug at the lower tier is not clinically appropriate (e.g., it will be or has been ineffective or would have adverse effects.) We may also request clinical documentation to support this statement. If We do not approve coverage for the Prescription Drug on the higher tier, the ancillary charge will not apply toward Your Out-of-Pocket Limit.

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

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 Deductible and Out-of-Pocket Limit.

This provision only applies to: 1) a Brand-Name Drug without an AB-rated generic equivalent, as determined by the FDA; 2) 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 3) all Generic Drugs.

13. **Participating Pharmacies.** For Prescription Drugs purchased at a retail, mail order or designated Participating Pharmacy, You are responsible for paying the lower of:
    - The applicable Cost-Sharing; or
    - The Prescription Drug Cost for that Prescription Drug. (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

    In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at 1-855-283-2150 or visit Our website at www.emblemhealth.com to request approval.

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

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

- Anti-Emetics;
- Bisphosphonates;
- Cardiovascular;
- Cystic fibrosis;
- Fertility;
- Gaucher's disease;
- Hepatitis Medications;
- Select Iron overload and Iron toxicity agents ;
- Oral Multiple Sclerosis;
- Select Orphan Drugs used to treat rare conditions such as Alpha-mannosidosis, Friedreich's ataxia, Fabry disease and rare blood cancers;
- Oral Osteoarthritis;
- Pulmonary arterial hypertension;
- Pulmonary diseases/Asthma;
- Transplant;
- Parkinson's Disease;
- Oral inflammatory and Anti-Rheumatologic drugs;
- Some Vaccines commonly administered in a pharmacy, such as vaccines for HPV, shingles, chickenpox and measles.

5. **Designated Retail Pharmacy for Maintenance Drugs.** You must fill Your Prescription Order for Maintenance Drugs for up to a 90-day supply at a Designated retail Pharmacy after an initial 30-day supply and two refills. 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.)

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).

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

- Asthma;
- Behavioral Health;
- Blood pressure;
- High cholesterol;
- Alzheimer's & dementia;
- High Blood pressure;
- High cholesterol;
- Hypertension;
- Arthritis;
- Heart disease;
- Chronic kidney disease;
- Cancer;
- Emphysema;
- Chronic bronchitis;
- Chronic obstructive pulmonary disease (COPD);
- HIV/AIDS;
- Osteoporosis;
- Multiple sclerosis;
- Cystic fibrosis
- Crohn's disease

You or Your Provider may obtain a copy of the list of Prescription Drugs available through a Designated retail Pharmacy by visiting Our website at www.emblemhealth.com or by calling 1-855-283-2150. The Maintenance Drug list is updated periodically. Visit Our website at www.emblemhealth.com or call 1-855-283-2150 to find out if a particular Prescription Drug is on the maintenance list.

7. **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 www.emblemhealth.com or by calling 1-855-283-2150.

7. **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.

8. **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 www.emblemhealth.com or by calling 1-855-283-2150.

9. **Formulary Exception Process.** If a Prescription Drug 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. 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 at www.emblemhealth.com or by calling 1-855-283-2150 to find out more about this process.

10. **Standard Review of a Formulary Exception.** We will make a decision and notify You or Your designee and the prescribing Health Care Professional no later than seventy-two (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.

11. **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 no later than twenty-four (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.

12. **Supply Limits:** Except for contraceptive drugs, devices, or products, We will pay for no more than a thirty (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 thirty (30)-day supply.

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

    Benefits will be provided for Prescription drugs dispensed by a mail order pharmacy or a designated pharmacy that participates for maintenance drugs in a quantity of up to a ninety (90)-day supply. You are responsible for one (1) Cost-Sharing amount for a thirty (30)-day supply up to a maximum of three (3) Cost-Sharing amounts for a ninety (90)-day supply.

    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 www.emblemhealth.com or by calling 1-855-283-2150. 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.

13. **Initial Limited Supply of Prescription Opioid Drugs.** If You receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be the same Copayment that would apply to a thirty (30)-day supply of the Prescription Drug. If You receive an additional supply of the Prescription Drug within the same thirty (30)-day period in which You received the seven (7) day supply, You will not be responsible for an additional Copayment for the remaining thirty (30)-day supply of that Prescription Drug.

14. **Split Fill Dispensing Program.** The split fill dispensing program is designed to prevent wasted Prescription Drugs if Your Prescription Drug or dose changes or if We contact You and You confirm that You have leftover Prescription Drugs from a previous fill. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get a fifteen (15)-day supply of Your Prescription Order for certain drugs filled at a pharmacy instead of the full Prescription Order. You initially pay half the thirty (30)-day Cost-Sharing. The therapeutic classes of Prescription Drugs that are included in this program are: Antivirals/Anti-infectives, Multiple Sclerosis, and Oncology. This program applies for the first sixty (60) days when You start a new Prescription Drug. This program will not apply upon You or Your Provider's request. You or Your Provider can opt out by visiting Our website at www.emblemhealth.com or by calling 1-855-283-2150.

15. **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.

I. Medical Management

The Certificate 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.

3. **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 Covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

   Preauthorization and utilization review is required to obtain certain Prescription Drugs, which include but are not limited to migraine medications, anti-nausea medications, anti-fungal agents, anti-inflammatory agents, appetite suppressants, asthma/COPD medications,

eczema medications, vitamin A-based medications -for treatment of cystic acne and other drugs and drug classes listed in this section.

If Your prescription is for a drug that is subject to Preauthorization, Your physician should contact EmblemHealth's Pharmacy Benefits Services Department (PBSD). Our PBSD staff and Your physician will decide, based upon Our clinical guidelines, whether the prescription is Medically Necessary for Your treatment or condition. Our PBSD staff and Your physician will also decide, based upon the guidelines, whether the quantity or duration of the prescription is medically appropriate. Our PBSD staff will then notify You and Your physician of its decision(s).

If the prescription request is approved, then the pharmacist will fill Your prescription and We will cover the prescription. If the prescription request is not approved, then We will not cover the prescription. If the prescription request is approved, but at a reduced quantity or duration, then We will cover only the reduced quantity or duration of the drug.

Our PBSD staff will make its decision(s) in the time periods and in accordance with the other requirements that apply to utilization review decisions. If You disagree with the PBSD staff's decision(s), You may file an appeal. (Please refer to the section entitled Utilization Review of the Certificate for information about timeframes and how to file an appeal).

Prescription Drugs in the drug classes listed below are also subject to Preauthorization. Examples of common drugs in the class are listed with each class.

- **Anti-Nausea Medications**, such as: Anzemet and Zofran.
- **Anti-Depressant Medications**, such as: Prozac; Paxil/Paxil CR; Celexa; Lexpro; Sarafem; fluvoxamine, Pexeva; Zoloft; Effexor/Effexor XR and Cymbalta.
- **Anti-Fungal Agents**, such as: Diflucan; Lamisil; Penlac; Sporanox and Vfend.
- **Anti-inflammatory Agents**, such as: Ponstel; Arthrotec; and Mobic.
- **Appetite Suppressants**, such as: Xenical; benzphetamine hydrochloride and phentermine hydrochloride.
- **Blood Pressure Medication**, such as: Lotensin; Vasotec; Prinivil; Accupril; Altace; Vaseretic; Prinzide, Zestoretic; Lotrel; Avapro; Cozaar; Diovan HCT; Avalide and Hyzaar.
- **Cholesterol Lowering Medications**, such as: Meavacor; Zocor; Lipitor; Crestor and Lescol.

- **Diabetic Medications**, Symlin; Trulicity; Tradjenta; Jentadueto/Jentadueto XR, Steglatro; Steglujan; Segluromet; alogliptin; alogliptin-metformin; alogliptin-pioglitazone; Nesina; Kazano and Oseni.

- **Eczema Medications**, such as: Elidel and Protopic.

- **GI Medications that Block Acid Secretion**, such as: Prevacid; Prilosec; Nexium; Protonix and Aciphex.

- **Asthma/COPD Medications**, such as: Singulair; Accolate; Proair; Tudorza Pressair and AdvairDiskus

- **Migraine Medications**, such as: Imitrex; Axert; Relpax; Maxalt and Zomig.

- **Narcotics/Opioids**, such as: Fentora; Opana; Opana ER; OxyContin; Kadian; Exalgo; Avinza and Actiq.

- **Osteo-Arthritis/Anti-Inflammatory Medications**, such as: Celebrex.

- **Vitamin A Based Medications for Treatment of Cystic Acne**, such as: Retin-A; Retin-A micro and Avita.

For a complete list of Prescription Drugs that need Preauthorization, please visit Our website at www.emblemhealth.com or call 1-877-793-6253. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under Your Certificate. 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 Drugs 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.

J. Limitations/Terms of Coverage.

6. 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.

7. 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 thirty-one (31) days of the date We notify You, We will select a single Participating Pharmacy for You.

8. Compounded Prescription Drugs will be Covered only when all ingredients are Covered legend Prescription Drugs, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from pharmacy that is approved for compounding. All compounded Prescription Drugs over $250 require Preauthorization. Compounded Prescription Drugs are on the tier of the primary ingredient. .
4. 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.

16. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of the Certificate.

17. 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 the Outpatient and Professional Services section of the Certificate.

18. 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 the Certificate. 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 or more Prescription Drug(s) and may be packaged

with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.

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

20. 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.

21. 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.

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

K. 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. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

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

L. 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.

5. **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.

6. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under the Certificate. This list is subject to Our periodic review and modification (generally quarterly, but no more than (4) times per Plan Year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website www.emblemhealth.com or by calling 1-855-283-2150.

7. **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. **Maintenance Drug:** A Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drugs.

12. **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.

13. **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.

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

14. **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.

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

16. **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.

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

H. Controlling Certificate.
All of the terms, conditions, limitations, and exclusions of Your Certificate to which this Rider is attached shall also apply to this rider except where specifically changed by this Rider.

Signed for Health Insurance Plan of Greater New York

Michael Palmateer

Michael Palmateer
Chief Executive Officer

Preferred Prescription Drug Schedule of Benefits Rider

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.	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
30-day supply • Generic • Formulary • Non-Formulary	20% Coinsurance, but not less than a $5 Copayment 40% Coinsurance, but not less than a $25 Copayment 50% Coinsurance, but not less than a $40 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PRESCRIPTION DRUGS (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Designated Retail Pharmacy			
90-day supply • Generic • Formulary • Non-Formulary	$12.50 Copayment $50.00 Copayment $75.00 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Mail Order Pharmacy			
90-day supply • Generic • Formulary • Non-Formulary	$12.50 Copayment $50.00 Copayment $75.00 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PRESCRIPTION DRUGS (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Enteral Formulas			
30-day supply • Generic • Formulary • Non-Formulary 90-day supply • Generic • Formulary • Non-Formulary	20% Coinsurance, but not less than a $5 Copayment 40% Coinsurance, but not less than a $25 Copayment 50% Coinsurance, but not less than a $40 Copayment $12.50 Copayment $50.00 Copayment $75.00 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

SECTION XXXII

Designated Hospitals Rider

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.

Designated Hospitals are hospitals and providers that we have approved and designated as specializing in certain types of services.

When you use one of our Designated hospitals, you will have a lower hospital cost-sharing than if you used another Participating Hospital for these services. This applies to all inpatient and outpatient services provided and billed by the Designated hospital. Covered services you receive from doctors and other providers while you receive care at a Designated Hospital will be covered according to the terms and conditions that otherwise apply to the type of service and provider under this Certificate.

Our Designated Hospitals are listed in the Schedule of Benefits Section of this Certificate.

Other Terms and Conditions
Except as specifically provided otherwise herein, all terms, conditions, limitations and exclusions of your HMO Certificate of Insurance remain in full force and effect.

Health Insurance Plan of Greater New York

Michael Palmateer

Michael Palmateer
Chief Executive Officer

Designated Hospitals
Schedule of Benefits

Designated Hospitals	**Designated Hospital Member Responsibility for Cost-Sharing**
Inpatient Oncology* **Memorial Sloan Kettering Hospital** Referral Required	$0 Copayment
Outpatient Oncology* **Memorial Sloan Kettering Hospital** Referral Required	$0 Copayment
Inpatient Orthopedics* **Hospital for Special Surgery** Prior Authorization Required	$0 Copayment
Outpatient Orthopedics* **Hospital for Special Surgery** Preauthorization Required	$0 Copayment

***** Includes only covered services provided and billed by the hospital